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ABSTRACT

Little is presently known of the implications and consequences of rehospitalizations of former mental patients. This research attempts to assess the consequences of rehospitalization for the patient, his family and for the professional (his psychiatric social worker) who attempted to serve him while he lived in the community. It examines the ways in which the various persons involved perceive the patient--his role in the community and his readmission. It is based on data concerning 249 consecutive readmissions of leave of absence patients occurring at Stockton State Hospital during a five and one-half month period. Results indicate that rehospitalization causes a breakdown in communication between the patient and his family, and that overt rejection is often the result. Also, those patients who are able to be self-supporting financially are least likely to be readmitted to the hospital. (Author/HMV)

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Mental Hygiene

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WORLDS THAT FAIL
PART II: DISBANDED WORLDS: A STUDY OF RETURNS TO THE MENTAL HOSPITAL

by

DOROTHY MILLER, M.A.
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"When situations are defined as real,
they are real in their consequences"

W. I. Thomas
Dorothy Swaine Thomas

To the memory of Manford H. Kuhn, a great sociologist, and a kind and gentle man, who taught me to wonder and to dare, I dedicate this attempt to add knowledge to the symbolic interactional theory of human behavior.

Dorothy Hillyer Miller
one of his many students

PREFACE

This is Part II of a study of "Worlds That Fail." Part I was published as California Mental Health Research Monograph Number 6. This part, like its predecessor, was supported by a grant from the National Institute of Mental Health (Grant MH 1269-1).

The preceeding part dealt with 1045 consecutive leave patients seen in the Oakland Bureau of Social Work during 1956; this part is based on data concerning 249 consecutive readmissions of leave of absence patients occuring at Stockton State Hospital during five and one-half months from October 15, 1963 to April 1, 1964. Leave of absence patients constitute about one-half of the total releases. The other one-half are patients who are discharged. When discharged patients return to the hospital, they are counted as readmissions. (A companion study of such readmissions is now underway and will be published in the future).

Part II is intended to be an exploration of the meaning of rehospitalization to three participants in the incident of the patient's return to the mental hospital, i.e., the returning patient, his significant other, and his psychiatric social worker from the Bureau of Social Work. For example, in many cases, the incident of rehospitalization might be seen as a therapeutic gain for the patient, at least as viewed by the professional. Relatives, too, often see a patient's rehospitalization as the best solution to an extremely hazardous and difficult situation. Often the patient may welcome a return to a mental hospital ward as a sanctuary from the disorder and terror of a sense of loss of control or extreme social stress. But each rehospitalization may also be viewed as a "failure" by each of the three participants.

Little is presently known of the implications and consequences of rehospitalizations of former mental patients. In a sense, the high return rates found in the study reported in Part I are relatively meaningless without the accompanying attempt to assess these implications and consequences of rehospitalization to the patient, to his family, and to the professional who attempted to serve him while he was in the community. This study attempted to relate the different role players' definitions of the situation to the patients' prior civilian careers.

We believe such data can make an assessment of return rates more meaningful and may help the patient and his family to receive better care and understanding in the psychiatric treatment situation. We further hope that these data may add to our knowledge of the importance of investigating the way people define their problems in order to develop new and helpful attitudes and solutions.

September 11, 1965 Dorothy Miller

ACKNOWLEDGEMENT

Stockton State Hospital maintains a long and proud tradition of research, and we deeply appreciate the cooperation given to us by Superintendent Freeman Adams, M.D., by Robert Griswold, M.D., Chief of Research, by Warren Webb, Supervising Psychiatric Social Worker, by the admission staff personnel and by many others at the hospital who welcomed us and aided us in our difficult task of interviewing subjects at the earliest possible moment after the patient's return from leave of absence.

We also owe a great deal to the psychiatric social workers in the Bureau of Social Work who helped us collect much of our data and who gave of their time and information. J. J. Ploscowe, Regional Supervisor of the Bureau of Social Work, as co-investigator of this project, aided us by his assistance in many of the administrative tasks involved in so ardous and ambitious an undertaking.

We wish to thank our consultants, Erving Goffman, Ph.D., Professor of Sociology, University of California, Berkeley, and Leonard Schatzman, Ph.D., Sociologist at the University of California Medical School, San Francisco, who gave us a great deal of guidance in this work. David Gold, Ph.D., Chairman of the Sociology Department, University of California, Santa Barbara, consulted with us regarding the methodological and analytical problems. Our colleague, Esther Blanc, University of California School of Nursing, Berkeley, also assisted us in several phases of this project.

Frances Day Brick, our typist, survived our frantic rush, and deserves much of the credit for meeting all the deadlines. Robert Barnhouse, our research assistant, worked long and hard on this material.

Robert Ross, Ph.D., and Ernest Dondis, Ph.D., of the Department of Mental Hygiene, Research Bureau, supported us with their advice and suggestions and we are deeply appreciative of their help.

Alden Mills, Editor, Research Publications, Department of Mental Hygiene, has been a stalwart guide and friend throughout the tortuous revisions of this manuscript. Without his help, encouragement, and keen editorial skills, this publication would not have been possible. He and his staff deserve our sincere gratitude.

William Dawson, ACSW
Research Interviewer

Dorothy Miller, ACSW
Project Director

WORLDS THAT FAIL

PART II - DISBANDED WORLDS

Table of Contents

THEORETICAL FRAMEWORK

As releases increase, so do re-entries of mental patients to state hospitals; they now constitute a major national mental health problem. For example, in California within a one-year period four out of ten released mental patients will be back in the state hospital.[1] While ex-patients spend relatively more time in the community than they do in the hospital, the question remains as to the consequences of such a situation to the patient and to the community. How are such re-entries into the hospital defined? Is there a point of diminishing return, where both the patient and the community have exhausted their supplies of hope and their resources until the state hospital eventually becomes the patient's final home?

If we wish to learn the answer to these, and a series of similar questions, we must get closer to an understanding of the patient's world. We must investigate his definition of his own situation. We then need to match up the patient's view of his world with the world's view of him. We believe that if we could do this, we would be closer to understanding the meaning, the consequences, and the future course of the rehospitalization process.

We, therefore, examined these propositions by setting up interview schedules (See Appendix) for those three persons thought to be closest to the patient's actual situation that led to the re-entry into a state mental hospital. The patient himself was asked to tell us why he returned, along with other facts about his community career. The patient's closest other, or the person most influential in bringing about the decision to return the patient, was also asked about the reason for his return. Since each returning patient in this study had been on leave of absence, he was also known to the Bureau of Social Work psychiatric social worker, who contributed her view of the reason for the patient's rehospitalization.

Thus, we sought a three-dimensional view of the same incident, as seen through the eyes of the patient, his significant other, and his psychiatric social worker. We found, as did the three blind men, that each person's definition of reality differed depending upon his perspective, upon his position of viewing, and upon his distance from the social interaction.

It is essential for such an analysis to consider the position of each of these sources of data in relation to the incident under study. Each of these participants has a different stance, a different status alignment to the situation. Each has different formal or informal, professional or personal, requirements inherent in that status. In no case can one of these views be considered as being more "correct" than the others, nor can they be considered in isolation. Unfortunately, due to the severe technical limitations in the social sciences, we often speak, in our analysis of the data, as if these three views of the world stood alone.

But, given that each of these three perspectives are related, it is not exactly clear what are the attributes and characteristics of each relationship. For example, perhaps the significant other holds the "controlling interest" in the patient's fate and thus may omit the social worker from the decision-making process, or vice versa. Or, perhaps the patient exerts such strong influence that he, in fact, determines his own fate without any strategic interaction with one or both of the other informants. We must approach the study of these three definitions of the return with considerable caution and understanding.

We offer here a general description of the alignment we felt each participant had to the return situation and develop a theoretical scheme of interaction which takes into account the status and requirements of each role.

First, the status of the posthospital patient, we know from our previous research, is, in general, a tenuous one - one where the patient may not be in full control of his own destiny. When a patient is released from the state hospital, in the majority of the cases he returns to his former living arrangement. If the initial commitment occurred in the midst of family conflict, residual bad feelings may complicate the resumption of family life after the patient's release from the mental hospital. At best, the released patient must pick up the main threads of his life again after several weeks, months, or even years of community moratorium. The patient must be, in some degree, dependent upon others in establishing a civilian identity. In addition, the patient released on leave continues to bear his patient label - he continues as a "hospital case" under supervision by a professional social worker. He may be continuing on fairly large doses of drugs. He is still "sick" in some ways, as he is forced to define himself and as he is defined by others.

In a certain sense he is under surveillance by others and he may neither understand nor accept such a suspect status. He comes from an institutional setting where all of the routine of living had been firmly established and he now moves into a family unit or some sort of social unit which has been functioning without him. He was expendable and remains in a state of "expendability." He must constantly check the validity of his welcome and of his own sense of worthy selfhood. He may retain a sense of embarrassment, bewilderment, and fear about his former behavior. He is the marginal man and, as such, is subject to all the fears and tensions which are inherent in this marginality.

Only 40% of the released patients maintain a marital relationship, and in the majority of these cases there is severe marital conflict. Among spouses, three-fourths have minor children in the home, who may need more emotional support than released patients are able to give. If the ex-patient is the head of his household, he will be expected to become the breadwinner. Yet, in less than half of the cases is he able to obtain any kind of employment. If he owned a car, it may have been repossessed, and he may have had his driver's license suspended.

If the ex-patient lives with parents, siblings, or other relatives, he may find himself "on the shelf," tangential to the central life of the family unit. In such circumstances he may adapt only by taking a passive or a dependent role. Very likely, he will not be a party to any major decisions with-

in the family and may, indeed, find himself living alone even in the family household. The aged woman patient, for example, who comes into her daughter-in-law's home may find it necessary to make a radical change in her life style in order to fit into the prescribed niche held for her.

For those who reside outside of the family, the problems of lonely independence are immediate and pressing.*

As we can see, the patient's situation is likely to be marginal and anxiety-producing, at least during the initial period of community adjustment. There is generally an air of optimism and hope overlying the anxiety when the patient readies himself to leave the hospital, but, after a few days, the "honeymoon" period ends and a backlash of broken dreams and austere reality confronts the ex-patient. Expectations which he has for himself may conflict, in a wide range of ways, with the expectations of others. Given this problematical status, it does not seem surprising that so many patients find themselves being readmitted to the mental hospital.

The ex-patient has been advised that he is "on leave of absence". He may or may not fully comprehend what this means. He is seen by the Bureau of Social Work worker in 70% of the cases, but may feel he is being "checked up on" or under some sort of official surveillance. He may be unaware of or unable to accept casework services. He may not be able to solve his problems by talking about them, no matter how "nice" or "pleasant" the social worker may be. He may not be able to understand the contacts between the social worker and his family. Are they taking place "behind his back"? Or, he may expect the social worker to prevent his being rehospitalized when, in fact, his significant other delivered him back to the hospital without the Bureau of Social Work worker's awareness or participation in the decision. The patient's view of the family situation and of the social worker may differ greatly from their view of him.

The incident of rehospitalization itself brings into sharp accent all of the frustrations, disappointments, and bitterness that may have been building up while the patient was in the community. He may feel his return to the hospital is the result of being rejected or abandoned by his family; he may feel overwhelmed with the reality burdens of his life and welcome even the mental hospital ward in contrast to the harsh external world; he may have experienced isolation and alienation to such a degree that a return to the hospital represents a "homecoming"; he may be so confused and upset that the return itself is only one more bizarre occurrence in his bewildering world. But, whatever his definition of the return may be, it must be seen in the perspective of what his status and requirements in the community have been. We feel that the way the returning patient defines his return will have a considerable impact upon the kind of psychiatric treatment from which he will be able to profit.

The patient's significant other may be a spouse, an aged parent, an adult son. His relationship to the ex-patient may have deteriorated or

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* See, Miller, D., 'From the Ward Into the World," unpublished paper, Bureau of Social Work, Social Research Laboratory, 1963, for a statistical description of the initial period of transition from the hospital to the community.

nearly vanished during the time the patient was hospitalized. During the patient's absence from the home, life went on; the family unit was maintained in some way. New roles, new job assignments filled in the gap left by the patient. In many cases, it may be supposed that the hostile, destructive interaction which preceeded the hospitalization left many scars, and that the absence of the patient from the home may have given other family members a welcome respite. Thus, the re-entry of the patient into the family may be viewed with trepidation, guilt, or overt hostility. Certainly the relationship between family members is in a fragile state, and there is a great deal of realignment and readjustment necessary if a new life is to be made.

Most of these state hospital patients come from the lower socio-economic class; many exist on some form of public assistance or earn only a marginal wage. For example, in some cases when the patient is released to live in his aged parents' home it may mean that the parents' old age pension check will just not be sufficient. The patient's return then represents a bitter hardship for one entire family unit. In other cases, the patient represents an emotional intruder who may create fear and tension. The family is uncertain of his behavior; they may actually be afraid of the patient's rage and irrationality. After all, he has been "crazy." At best, it seems likely the relationship between the significant other and the patient will be overlain with some degree of guilt, anxiety, or worry.

Many of these relatives have little or no intellectual understanding of "mental illness"; they tend to think of the patient's past episodes as "misbehavior," "temper," "drunkenness" or "the blues." Many may have expected to see the patient's personality remade in some miraculous way as the result of hospital treatment, and are, thus, disappointed. Whatever the affective level between the patient and his significant other might be, it seems unlikely that the Bureau of Social Work psychiatric social worker would be seen as a source of support and understanding. Many of these families view a social worker as an "out-sider," albeit pleasant, but something outside ordinary exchange. The significant other may feel that the social worker doesn't understand the patient's behavior in the home, and may feel the social worker is preventing the patient from being back in the hospital.

Under such circumstances, the relative may "by-pass" the Bureau of Social Work worker and return the patient directly to the hospital after the situation in the home has worn them all out. In some cases relatives may see the patient as needing a great deal of protection, support, and care which, somehow, the social worker has either not provided or has encouraged the relative not to offer; advising that the patient should be encouraged to be "free," "be independent." For these, and a number of other reasons, the significant other may see both the patient and the Bureau of Social Work worker quite differently than they see him.

The Bureau of Social Work psychiatric social worker has a caseload of approximately 80 leave patients, some of whom are in family care homes and some who require intensive services. She may have a territory covering a large geographical area. Frequently, a patient is released from the hospital for several days to three weeks before she is notified that he is in the community. Her correspondence or telephone inquiry may not result in an

appointment being either made or kept. Her professional requirements mean that, in general, she will work first with those patients who are accepting of casework services or who are in some crisis state which requires immediate attention. In order to carry out welfare, vocational rehabilitation, or employment referrals, the social worker must spend much time and effort routing people and paper to the correct agencies or persons. The leave patient who does not either request help or require crisis service is likely to be placed on a routine stand-by list, to be seen at intervals of several months, as long as the patient or the family can manage somehow.

The worker attempts to teach the ex-patient and his significant other what her professional role is and how she can be used to help. However, as we can see, both the patient and his significant other may be unable to accept or understand the psychiatric social worker's role. The patient, for example, may not be able to comprehend what she means by "help" when she cannot find him a job, or get a "relief" check started for thirty to sixty days. The significant other may be unable to trust the worker's offer to help the patient stay out of the mental hospital when, in fact, the relative feels the patient should be returned. Advice from her on this issue may fall on deaf ears.

The end result of such a set of status alignments in this situation is likely to result in a "stand-off" for all three participants. Each may be communicating outside the "receiving bands" of the other.

Another way of examining the reasons for return given by the three participants is to look at Goffman's scheme of "cooling the mark"(2) For example, he stated:

> It is well known that persons protect themselves with all kinds of rationalizations when they have a buried image of themselves which the fact of their status does not support. A person may tell himself many things: that he has not been given a fair chance; that he is not really interested in becoming something else; that the time for showing his mettle has not yet come; that the usual means of realizing his desires are personally or morally distasteful or require too much dull effort. By means of such defenses, a person saves himself from committing a cardinal social sin - the sin of defining oneself in terms of a status while lacking the qualifications which an encumbent of that status is supposed to possess.

For the returning mental patient, an additional institutionalized rationalization is also available. He may say he is "sick" and thus unable to fulfill his roles. Likewise, his family's and his professional's view of their "failure" to provide somehow a new world, albeit unrealistic, may also take similiar modes of explanation. Such "rationalizations," "explanations," and "perspectives" are indeed well known: for example, Freud's development of the projective mechanism describes the same phenomenon.

The purpose of this research project is to examine the way each of these three participants defined the situation which led to the patient's return to the mental hospital. We assume that the way each of the three participants defined the reasons for return has a direct bearing upon their

subsequent actions and, therefore, is a vital focus for research.

Thus, we attempt to look at the patient's return to the mental hospital by utilizing three perspectives. By considering the professional and personal requirements of (1) the patient, (2) his significant other, and (3) his social worker, we feel we may come closer to understanding the reasons for the patient's rehospitalization.

SETTING

Stockton State Hospital, located in Stockton, California, serves the mentally ill of a large area of north-central California, including patients from the Oakland, California, metropolitan area. Patients who are released on leave of absence from this hospital may be returned to the hospital from leave, without the necessity of any formal readmission procedure. That is, the leave patient who is brought to the doorstep with an indication of difficulty may be immediately readmitted to his former ward.

The admitting office is staffed by psychiatrists, nurses, and attendants. Returning patients are examined by a psychiatrist, who then readmits them to their prior hospital ward, if this seems advisable. During the five and one-half months of this study, no leave of absence patient who came or was brought to the admitting office of this mental hospital was turned away.

Because our study focused upon the reasons for the patient's return, we felt it was necessary to interview returning patients as soon as possible, preferably within the hour, after their re-entry into the hospital. Therefore, the research interviewer was stationed close to the admitting office and saw the returning leave patients as soon as possible after they entered the hospital door. Three-fourths of all patients who were returned during a working day were interviewed that same day, while one-half of these were seen within one hour of their return.

The interviewer, an experienced psychiatric social worker, was able to obtain relevant responses to our structured questionnaire (See Form 1 in the Appendix) from 89% of all returning patients - only 11% of our subjects gave incoherent or irrelevant or no responses in the course of the interview! We were surprised, since we expected a higher proportion of returning patients to be so confused, so hostile, or so overwhelmed that their responses possibly would either be not relevant or unobtainable. It seems that even at the admitting office of a mental hospital, returning mental patients are able to exert a reasonable amount of personal control which enables them to communicate about their views of their own worlds.

The hospital was also the setting for interviewing the patient's significant other, whenever this was possible. In most cases it was necessary to contact these significant others in their homes, by a visit, by mail, or by telephone. Thirty-eight percent came into our interviewer's office for a structured interview, while 45% responded by completing our mailed questionnaire (See Form 2 in the Appendix.) In 5% of the cases there were no significant others; i.e., the returning patient lived alone or had no close contacts with a reliable informant. Of those cases where there was a significant other, we were unable to locate 2% and 11% made no response to our repeated contacts for information.

The Bureau of Social Work psychiatric social workers were sent a questionnaire from the Social Research Laboratory office in the Bureau of Social Work in San Francisco and were asked to complete it and return it by mail. (See Form 3 in the Appendix)

Thus, these data were collected from four sources in two settings - (1) the hospital record data and (2) the interviews with the patient and significant other were obtained at the research unit located in Stockton State Hospital; (3) the data from the remaining significant others and (4) the patient's Bureau of Social Work worker were obtained by return mail to the research office located in San Francisco.

The coding and analysis of the collected data were carried out in the Social Research Laboratory in San Francisco and by the Survey Research Center, University of California at Berkeley.

POPULATION AND SAMPLE

Approximately 22% of the total mental hospital population in California are released on leave of absence each year. About the same proportion are directly discharged. How the civilian careers of these two groups compare remains unclear. Originally, we planned to study the reentry of all patients to a state hospital, including not only those patients returning from a leave of absence period, but also those patients readmitted via a new admission procedure. We conducted a pilot study of the flow of patients through each of these two mental hospital doors and we learned that we could expect at least 500 patients to re-enter the hospital during the six month study period - about 250 each of leave patients and readmitted patients.

We learned the administrative procedure dealing with the readmitted patients and their families would have made it difficult for us to interview these patients because of the heavy influx of patients which occurred on one day. Since our staff was not large enough to be able to handle more than five or six interviews each day, and because of other technical difficulties, it was necessary for us to focus this investigation upon the returning leave patients only.

After we conducted a number of pilot interviews with the returning leave patients and their significant others, we constructed our questionnaires in final form (See Appendix). We began in October, 1963, to interview each consecutive returning leave patient. During the period between October 15, 1963, and April 1, 1964, there were 256 returned* leave patients interviewed. Of this number, seven were duplicate interviews; i.e., these seven were patients who had returned from leave once, had subsequently been placed on leave again, and were then returning to the mental hospital for the second time within our study period! These duplicate cases (3% of total

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* We excluded a very few "paper returns," such as administrative changes in status. We interviewed those leave patients who were, in fact, undergoing rehospitalization as a termination of their leave of absence status.

interviewed) were analyzed separately. For purposes of this report, only the return that occurred first in the six month period was analyzed. A brief report of our seven "shuttle-bus" patients was published in Mental Hygiene in July, 1965.

Thus, our sample consists of interviews with 249 consecutive returning leave patients over a five and one-half month period. We believe that these patients are representative of all leave patients returning to this hospital, although we do not claim that our data apply equally to the re-admitted patients. We speculate that a more serious or acute problem may be necessary to precede a patient's readmission than would be the case for a patient to be returned from leave. The readmitted patient must be brought again before the commitment commission, and perhaps the relatives of discharged patients may endure an untenable situation over a longer period of time due to the need for them to take formal and legal steps to commit the patient all over again.* However, we hope one day a study of such patients could be carried out.

At the time of the interview with the returning leave patient, information was gathered from him regarding his most influential or "closest-other"; i.e., his significant other. We then arbitrarily assigned as the significant other that relative, friend, or community agent who, according to both the patient and his hospital record, seemed to be the most important person in the patient's world, the one most likely to have played an influential part in the decision to return the patient to the hospital. In 5% of the cases there was no significant other; i.e., the patient had lived alone without any appreciable or known ties to anyone while he had been in the community.

All other patients had a significant other, i.e., "someone" who knew something about the reasons why the patient had been rehospitalized. We were able to gather information for our study from 203 of the patient's significant others. Thus, of 236 patients who had a significant other, we obtained information from approximately 86%.

The reasons for this "shrinkage" of respondents were as follows: Among the thirty-three cases from whom we could not obtain data, there were six cases where the significant other "dropped out of sight" after delivering the patient to the mental hospital, much to the concern of the patient, who felt he had been abandoned. There were twenty-seven cases where the significant other refused to answer our several inquiries. Some advised us that they were so "through" with the patient that they would not complete our forms or discuss the return reasons with us. Undoubtedly some of these refusals were related to the tangential nature of the patient's relationship to the significant other. For example, some patients' significant others

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* Some families of leave patients request the Bureau of Social Work (BSW) worker not to recommend discharge of leave patients, even after a satisfactory twelve months in the community, because they feel it is "so much trouble to get the patient readmitted" to the mental hospital via the quasi-legal 'trial' at the commitment hearing. (Clinical observations by D. Miller).

were merely acquaintances, hotel keepers, tenants of the same building, etc. - i.e., they were in some ways "insignificant others." Sometimes the significant other was illiterate or had so poor an educational background that he could not complete the forms. Some did not have transportation in order to come to the hospital for an interview, or had no telephone, etc. And, of course, undoubtedly some did not reply because of their hostile or ambivalent feelings toward the patient. On the whole, we feel we were able to obtain a representative picture of the influence of these "significant others" with regard to the decision to return the patient to the hospital.

Inquiries were also sent to the BSW workers who had been assigned each leave patient's case. We were able to obtain BSW workers' responses in 91% of the cases. Those 9% who did not reply to our inquiry were, in general, cases which had been transferred from one worker to another, or from one office to another, so that our inquiry did not reach the proper source in time for the reply to be included in our analysis of the data.

Thus we gathered information from 249 returning leave patients, from 203 significant others, and from 227 BSW workers. We had no information from either the patient's significant other or the Bureau of Social Work in only five cases. In those cases, the patients had no significant others and were out in the community only a relatively short time; thus the BSW workers had perhaps not been able to contact them before they were back in the mental hospital again.

DATA AND DATA ANALYSIS

The primary sources of data were the interviews and questionnaires which the patients, significant others, and the professional social workers completed. The interviewer asked each respondent the questions, as worded, writing down, insofar as possible, in the respondent's own words, his answer to each question. Included at the close of both the patient's and the patient's significant other's form was an item which asked the interviewer to record his own clinical impression.

Schedules which were mailed to the significant other asked essentially the same questions as did the interview schedule. In general, the significant others were questioned over the same areas that the patient had been questioned; i.e., reasons for the patient's return, and his community career in terms of employment, support, ability to get along, etc. Mailed forms were received from 54% of the significant others, while 46% were interviewed. These two data schedules were compared and no significant differences were found between the responses except on the items concerning evaluations of the social worker's ability to help. Significant others who completed the mailed form were more likely to indicate that the BSW worker had not been of help, while those significant others who were interviewed were more likely to say the social worker had "helped." We can only conclude that in a face-to-face situation with the interviewer who was a social worker, relatives were less willing to admit to ambivalent feelings about social workers ability to "help." While this item clearly raises one issue of reliability, we can say that on all other item responses from the two schedules, no significant differences in the type or direction of response could be seen. On this basis we felt the responses from these two different types of instruments could be combined.

The schedules filled by the BSW worker asked for information only about the Bureau of Social Work contacts, as well as the worker's professional assessment as to what would be necessary in order to keep the patient in the community.

The responses to both types of schedules were coded by the use of the Berelson content-analysis technique, (3) using two independent raters. These raters were used in developing a set of codes for categorizing the subjective data extrapolated from the schedules. It was possible to develop broad categories where a high reliability coefficient could be maintained by these independent raters.*

The over-all reliability coefficient for the coding of these schedules was .85, or agreement on 85% of all coded items. This figure represents an average of the reliability of coefficients obtained throughout the coding period. Reliability checks were made at weekly intervals during this period. The formula for getting such estimates was as follows:

$$R = \frac{\text{Number of Coders X (Number of categories on which all coders agreed)}}{\text{Sum of all categories coded}}$$

Disagreements between coders centered mainly on the determination of the primary problem area, since no multiple problem codings were utilized. In general, we were able to discriminate between major or gross areas of similarity or difference in these responses.

These data were then punched on IBM cards. The machine facilities at Survey Research Center were utilized for the analysis. For this report we are only reporting on the simple and obvious relationships found between these three perspectives of the reasons for the patient's return to the mental hospital. We plan a series of future reports which will specify and interpret in greater detail the various facets of these data. For this report we seek to describe the world as seen symbolically through the eyes of the returning patient, his significant others, and the professional psychiatric social worker.

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* Copies of the coding instructions are available from the senior author on request.

FINDINGS AND DISCUSSION: THE PATIENT'S WORLD

We interviewed 249 patients as they re-entered the state hospital after having been in the community on leave of absence for an average of 6.4 months. From what these returning patients told us, we attempted to reconstruct their worlds as they perceived them. We were particularly interested in how they defined their return to the mental hospital, and what events in their community careers - their adventures, experiences, and relationships with others - led them back to the hospital door again.

Nearly all of these patients talked with us. Almost all discussed their situations willingly, with sensitivity and a reasonable degree of clarity. They had "a side" of a story to tell, and they presented it for our inspection. Some wept, some were in a state of inner rage, some were hurt and frightened, some were glad to be back "safe and sound," and some were even grateful for the special attention given them by the interview situation.*

We will first present some of the sociological factors we observed in this group of returning patients. We will then attempt to reconstruct some of the major incidents in their community life which seemed to lead them back into the mental hospital. In this section we attempt to get into the patient's own stance and to view his world from his own perspective. What is his "reality"? How does his definition of his life situation affect his actions and the ultimate reactions of others toward him?

Social Structure

First, let us examine the social structure in which these returning patients lived while they were in the community. For 50% of these patients, their return to the hospital was almost a routine event, since this was the third or more time they had been released, only to return yet again. In one-fourth of the cases this return was the fifth, or more, re-entry into the mental hospital! This group comprised "chronic" leave patients - the "in-and-outers" - "the shuttlebus riders."**

Most of these returning patients came from the lower socio-economic class. Approximately 70% had less than a high school education. Of those in the labor market, two-thirds were non-skilled workers and, of these, less than one-third were able to find any kind of work, even the most marginal or temporary job, during the time they were out of the mental hospital.***

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* See the item coded in frequency distribution on the interviewer's evaluation of patients' interaction with the interviewer (Appendix, Table 74).

** See Miller, Dorothy, "Chronic Leave Patients," unpublished report, Bureau of Social Work, Social Research Laboratory, San Francisco, 1963; also see - "Chronic Leave Patients: Passengers on the Hospital-Community Shuttlebus," Mental Hygiene, July, 1965. pp. 385-390.

*** See Miller, Dorothy and William Dawson, "Effects of Stigma on the Re-employment of Ex-mental Patients," Mental Hygiene, April, 1965, pp. 281-287.

One-third of these patients were financially dependent upon some form of public welfare and 35% were dependent upon their significant others as their prime source of support.

Forty-two percent of these returning patients had a history of mental hospitalization dating back longer than five years; 12% had a hospital history of more than fifteen years. Some of these patients seemed to be nearing the end of a long downward spiral in society - the mental hospital was becoming their final home. Yet, it is of interest to note that of the chronic leave patients with histories of five years or longer, one-half were resisting their rehospitalizations, claiming they were being victimized by others, and stating that they did not really belong in the mental hospital! Thus, we seem to find some indication that even the chronically-returned patient does not accept rehospitalization as the final answer to whatever difficulties he may have encountered in the community.

Of all those who returned, 38% were in some way involved with the police, although police actually initiated the patient's return in only 5% of the cases.(4) Relatives frequently called in the police to take the patient to a hospital; i.e., remove that patient from their homes. As further evidence of the distance between the patient and his significant others, in only 28% of the cases did the patient's significant other personally accompany the patient on his return to the mental hospital. Further, in 13% of the cases the significant other could not be located, or refused to respond to our efforts to gather data. In two cases the families replied to our inquiry with considerable bitterness and open rejection of the patients, and refused to take any part in even discussing the situation which led to these patients' rehospitalization.

Family Role Position

The family life of these returning patients was classified by their family role position, based on their actual living arrangement; i.e., "spouse," "child," "relative," "isolate," or "family care." (See Retrospective Study, i.e., Part I, for complete description of these categories.)

The following table shows the distribution of returning patients by their family role position prior to their return.

TABLE I: RETURNING LEAVE PATIENTS' FAMILY ROLE POSITION BY SEX (N = 249)

	Spouse		Child		Relative		Isolate		Family Care		Total	
Sex	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Male	26	10%	35	14%	11	4%	28	11%	8	3%	108	43%
Female	61	25%	17	7%	14	6%	34	14%	15	6%	141	57%
Total	87	35%	52	21%	25	10%	62	25%	23	9%	249	100%

As can be seen, 65% of all returning patients live outside of a conjugal family and hold tangential or isolated positions in relation to their kinship group. The fact that more women than men are rehospitalized is not

significant here, since more females are actually on leave in the community than are males (males are more likely to be directly discharged from the mental hospital, or never to have been admitted there in the first place).

When one examines the leave population figures in relation to the family role positions held by leave patients, (see Part I of this report), it can be seen that proportionately fewer spouses are returned to the mental hospital than are released on leave, while more sons and more male and female isolates are rehospitalized. That is, those patients who hold family role positions which indicate distant significant other relationships are more vulnerable to being returned to the mental hospital than are those who hold family role positions which indicate a close significant other relationship.

Treatment

The hospital careers of these returning patients show not only a long mental illness history, in general, but also show that almost one-half of these returning patients had received a course of electro shock therapy (EST) while they were in the hospital. Two of these returning patients had previously undergone a lobotomy. Almost three-fourths had been taking some type of psychiatric medication during the time they had been in the community, while nearly all had been on some type of drug therapy while in the hospital. It might be said that, in a sense, these returning patients are "medication failures" - the "magic pills" have not been enough to keep these patients out of the mental hospital since two-thirds also continued on medication while on leave. However, we have no indication whether the patients received amounts and kinds of medication that would be termed "adequate" according to present standards.

Further, 20% of these patients have not only been treated in California state mental hospitals, but have received psychiatric care in other psychiatric hospitals and clinics as well. According to the latest diagnosis, 60% of these returning patients are schizophrenic, 12% have some form of chronic brain syndrome, 13% are diagnosed as having some type of depression, and the balance are diagnosed as personality disorders (7%), mentally retarded (2%), and alcoholic (6%).

Thus, in general, the sociological facts about these returning patients present a picture of socially and psychiatrically-damaged persons. They have had long periods of psychiatric care with all sorts of treatment, including a considerable use of psychiatric drugs under medical supervision. With all of this, their level of social functioning appears to have continued to deteriorate over time. Seemingly, whatever few social resources they may have had when they were first admitted to a mental hospital have been eroding steadily away with each new episode of mental hospitalization. For example, during this last leave period, 16% of these patients changed their living arrangements from one family role position to another. Of those who changed, 65% changed from a "close-other" role position to a "distant-other" role position, e.g., from spouse to isolate, etc.; 25% changed from one dependent position to another, e.g., from son to relative, etc.; and only 10% moved into a "close-other" family role position, e.g., from isolate to spouse. Such a finding seems to constitute some evidence of these patients' movement downward in the social structure.

This overview of these sociological factors forms a social framework for understanding the returning patient's world and leads us closer to a comprehension of the frustration, pessimism, and despair which seem so characteristic of mental patients' families and of many professionals who deal with them.

The Patient's View

Such a grim sociological backdrop sets the stage for us to move closer to an understanding of the individual patient's view of his world and his definition of the reasons for his latest return to the mental hospital.

When the patient re-enters the hospital he must struggle to "save face" somehow, to hold on to some kind of dignity at a time of grim confrontation of his "failure." Just a few months ago he left the hospital with high hopes--and now he is back again. How can he present himself with pride; how can he ask for help or for hope, without losing whatever fragile sense of self he may have been able to retain? He must now submit himself to an admission ritual, answer questions, give up his civilian status and become what he seems always to have been - a mental patient. What reasons for this can he give to himself, to his family, or to the professionals?

We are now able to examine in some detail how the returning patient handles his pride and his situation by studying the reasons for his return as he gave them to us in the interview. The patients' reasons for return are shown below:

Reason	Number	Percent
Don't know, unknown	25	10%
Psychiatric illness	55	22%
Physical illness	35	14%
Family/financial stress	101	41%
Incoherent responses	26	10%
Drinking problem	7	3%
Total	249	100%

Only 22% of the returning patients stated that they were returning because of some type of a psychiatric problem such as "nervousness," "depression," etc. Another 10% were so bewildered, defensive, irrelevant, or incoherent in their answers that, while they did not explicitly give a psychiatric explanation for their return, it was obvious that they were disturbed in their ability to communicate or to order their thoughts coherently. Thus, only one-third of the returning patients were either defining themselves, or behaving, as one having a psychiatric problem. Of these patients who either were psychiatrically disturbed or who defined themselves as having a psychiatric illness, the significant other involved agreed with this definition of the situation in only 42% of the cases, and the psychiatric social worker agreed in only 46% of the cases. (In fact, the social worker and the significant other agreed with each other that the patient's return was necessitated by a psychiatric problem in only 54% of the cases!) It appears that the definition of the patient's behavior as being that of a psychiatric nature is by no means consensually held by

all of these three prime "situation-definers"!*

The other 68% of returning patients gave varied responses. Among these, the most frequently mentioned were some form of family conflict, distrust of others, or financial difficulties. Some of the total sample (19%), felt others had plotted against them or had returned them unfairly--in short, they indicated that they were being "victimized" by the family or the community in being returned to the state hospital. The balance (22%) of the total sample stated they were involved in some form of family conflict or financial stress, such as marital conflict, or unemployment.

The responses of victimization and family conflict together comprise 41% of all returning patients' responses. Such responses definitely indicate major areas of difficulty in the patients' social relationships. Yet, of this group, approximately one-fourth had not been in contact with their social worker at the Bureau of Social Work, according to the worker's report, during the time they were in the community. In these cases, the social worker did not have information regarding the community careers of these patients and did not know of their rehospitalization, since they had had no contact with these leave patients. One-half of the patients who defined their problem as family and environmental stress had been in the community less than three months - so that perhaps not enough time had elapsed for the worker to be in contact with the patient. The other half of the non-contacted patients had been on leave status more than three months, and it appeared that this group may have resisted or avoided con-

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* This lack of consensus seems best illustrated by the surprising findings regarding the response of an attempted suicide as the reason for rehospitalization. The patients, the significant others, and the social workers each listed three suicide attempts as the reason which necessitated the patients return to the mental hospital. Yet, when we compared the responses of these three groups with each others' definition of a suicide attempt as the reason for return, we found <u>they were not all reporting the same incident, but, rather, were reporting a total of eight different suicide attempts among these patients</u>! That is, the three patients who reported they were returning because of an attempt to take their own lives had the agreement of their significant other in only one case. In the remaining two instances the significant others made no response to our question in one case, and in the other case defined the return as being caused by the patient's drinking problem. In no case where the patient reported a suicide attempt as the reason for return did the social worker give this same incident as the reason for that patient's return. In those three cases, the social worker reported no contact with these patients while they were in the community. However, in <u>three other cases</u> the social worker reported the patient was returned because of a suicide attempt. Those patients, however, gave the following explanations of their return: two said the return was the result of family or environmental stress; one said he was psychiatrically ill. Therefore, as we can see, even an incident so explicit and startling as an attempt to destroy one's own life may be defined differently, denied to outsiders, or go unnoticed by those close to a leave-of-absence patient's life.

tact with their social workers. As evidence of this resistance, we found that one-third of these patients who were on leave more than three months reported in the return interview that they did not feel the social worker had been helpful to them.*

Some of the other reasons for returning, as given by the patient, were for physical reasons (14%). In one-third of these 35 cases the patient was supported by his significant other in this definition (Table II). The BSW worker, however, felt these 35 patients had been rehospitalized for physical reasons in only three of the cases (Table III). Thus, in at least two-thirds of the cases where the patient felt his physical condition led to his return, he stood alone without the consensual support of his significant other or his social worker in holding such a definition of the situation.

The work of Newcomb(5) and many other social psychologists points up the necessity for the development of consensual meanings among people if cooperation and the attainment of common goals are to be the result of social interaction. Yet, in this study we see wide discrepancies in the way three individuals viewed a common situation, and we feel that such a lack of consensus between them plays an important role in the patient's inability to remain out of the mental hospital (Table V).

Consensus Among Various Participants

When we examine the three pairs of responses made to our inquiry as to why the returning patient was rehospitalized, and eliminate the "don't know" responses, we find consensus on any type of reason in only 42%, 33%, and 50% of the cases, respectively, as shown in Table V.

Within the specific classifications of reasons given for the patient's rehospitalization, the degree of consensus between the three informants is still more widely at variance. For example, in Table VI each patient's reason for return is compared with the reason given by both his significant other and his social worker. As we can see, the greatest amount of agreement is found in the psychiatric and drinking problem definitions, and the least amount in the social stress definition (and in the physical problem so far as the social worker is concerned). As can be seen, there is, at best, only partial agreement between the patient and his significant other and between the patient and the social worker.

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* Of interest in these data was the possible effect of the interviewer upon the patient's response; i.e., in the cases in which the BSW worker reported no contact had been made with the patient, the patient at the time of his re-entry stated to the social worker interviewer that he had seen the social worker in the community. Further, 25% of these patients stated their social workers had, indeed, been helpful to them! It appeared the patients were either seeking to placate the interviewer, or, perhaps had, in fact, become confused as to who were their BSW workers, since many of these leave patients saw a number of agency workers, such as welfare, vocational rehabilitation workers, etc.

TABLE II: COMPARISON OF REASONS FOR PATIENT'S RETURN AS GIVEN BY THE PATIENT AND THE PATIENT'S SIGNIFICANT OTHER

	Patient's Reasons						
Sig. Other's Reasons	Unknown	Don't Know	Family & Environ.	Psychi- atric*	Physical	Drink- ing	Total
Unknown	[0]	3	19	23	2	2	49
Don't Know	0	[0]	5	1	1	0	7
Family & Environ.	1	6	[34]	17	4	2	64
Psychiatric	2	10	32	[34]	14	0	92
Physical	0	3	7	4	[11]	0	25
Drinking	0	0	4	2	3	[3]	12
Total	3	22	101	81	35	7	249

* Incoherent responses (26) were combined with psychiatric illnesses (55) to give this total of 81 patients. [ ] Indicates agreement on reason for patient's return.

TABLE III: COMPARISON OF REASONS FOR PATIENT'S RETURN AS GIVEN BY THE PATIENT AND THE PATIENT'S BSW WORKER

	Patient's Reasons						
BSW Reasons	Unknown	Don't Know	Family & Environ.	Psychi- atric	Physical	Drink- ing	Total
Unknown	[2]	2	17	21	12	1	55
Don't Know	0	[2]	7	8	5	0	22
Family & Environment	1	9	[18]	8	2	1	39
Psychiatric	0	8	50	[37]	11	1	107
Physical	0	0	1	4	[3]	0	8
Drinking	0	1	8	3	2	[4]	18
Total	3	22	101	81	35	7	249

TABLE IV: COMPARISON OF REASONS FOR THE PATIENT'S RETURN AS GIVEN BY THE PATIENT'S SIGNIFICANT OTHER AND BY THE PATIENT'S BSW WORKER

	BSW Worker's Reasons						
Sig. Other's Reasons	Unknown	Don't Know	Family & Environ.	Psychi-atric	Physical	Drink-ing	Total
Unknown	[11]	5	8	19	2	4	49
Don't Know	1	[0]	2	3	0	1	7
Family & Environ.	10	5	[19]	25	2	3	64
Psychiatric	21	10	6	[50]	0	5	92
Physical	9	2	3	7	[4]	0	25
Drinking	3	0	1	3	0	[5]	12
Total	55	22	39	107	8	18	249

TABLE V: CONSENSUS REGARDING ALL PARTICIPANTS REASONS FOR PATIENTS' RETURN (Unknowns Eliminated)

Consensus Between:	Number of Cases with Dual Responses	Number which Agreed	Percentage of Agreement
Patient and Significant Other	197	82	42%
Patient and BSW	193	64	33%
Significant Other and BSW	156	78	50%

TABLE VI: CONSENSUS REGARDING PATIENT'S SPECIFIC REASON FOR RETURN, COMPARED WITH SIGNIFICANT OTHER'S AND BSW WORKER'S REASONS
(Unknowns Eliminated)

Patient's	Total Patients Responding	Significant Other Agrees With Patient		BSW Worker Agrees With Patient	
Family/Social Stress	101	34	34%	18	18%
Psychiatric Problem	81	34	42%	37	46%
Physical Problem	35	11	31%	3	9%
Drinking Problem	7	3	43%	4	57%
Don't Know	22	0	0	2	9%
Total	246	82		64	

Many social workers believe that the casework process must start where the client is. Helen H. Perlman, in her book Social Casework[6], for example, puts considerable emphasis upon agreement between the client and the worker as to the definition of the problem as the necessary component for the development of a therapeutic relationship between them. One might even say that the types of problems agreed upon could be relatively unimportant, at least as a first step, so long as the worker and the client did, in fact, agree upon some problem. Our findings, therefore, raise many provocative questions for social work practice.

Since we found that only 33% of the patient's various reasons (see Table V) were in agreement with the psychiatric social worker's reasons for the patient's rehospitalization, can this finding be taken as indicating a serious lack of the basis for meaningful relationship between the patient and the social worker? Could this finding explain in some degree the patient's failure to stay out of the mental hospital? Of course, it is highly unlikely that, in view of the complexities of any social situation, any one factor would ever be sufficient to explain so complicated a pheonomenon as the patient's re-entry into the state hospital. Further, Bureau social workers, faced as they are with the complexities of their professional and program requirements, and with large caseloads, could not be expected to carry out sustained casework treatment with all leave of absence patients, or even with those who seem to be in a precarious

state of emotional stability. Furthermore, we cannot overlook the well known phenomenon of symptom repression among mental patients which causes them to deny, minimize, or rationalize their illnesses or social maladjustments.

Significant Others

A more reasonable expectation for aiding the patient might be found within the patient's family or social unit in his relationship with his significant other. Outside of an intensive treatment unit, no social worker can become the patient's significant other in the full sense of the word. Such emotional investment in a relationship generally exists only within kinship or long standing peer group relationships, or in an on-going intensive psychotherapeutic transference relationship. What of the patient's significant other? We will need to examine his world as it overlaps with the patient's world in order to understand this relationship.

Who are the returning patients' significant others? Table VII shows the type and proportion of the patients' significant others, as classified by their kinship alignment.

TABLE VII: REHOSPITALIZED PATIENTS' SIGNIFICANT OTHERS (N=249)

Significant Other	Number	Percent
Spouse	79	32%
Parent	58	23%
Relatives	50	20%
Non-family	55	22%
None	7	3%
Total	249	100%

In some cases where the patient was actually living with a family group, someone outside that living arrangement was his significant other; i.e., seemed to exercise the most influence over him. In 22% of the cases, someone external to the patient's actual living arrangement initiated, or had what appeared to be the managing control over the patient's community destiny and was named by the patient as that person who was nearest to him, responsible for him, etc. We believe this finding may empirically reveal some aspects of the fragile structure of the patient's family and kinship ties. It may also be an indication of a lack of a stable family

role position for that patient and his significant other within which to build a set of role expectations. Table VIII shows the patient's family role position in relation to the patient's significant other as found at the time of the patient's return to the mental hospital as to whether or not the patient's significant other was his role partner.

TABLE VIII: PATIENT'S FAMILY ROLE POSITION BY PATIENT'S SIGNIFICANT OTHER

Patient's Family Role Position	Significant Other					
	Closest Family Member		Outside Pt's. Living Arrange.		Total	
	Number	Percent	Number	Percent	Number	Percent
Husband	22	85%	4	15%	26	100%
Son	33	94%	2	6%	35	100%
Male Relative	9	82%	2	18%	11	100%
Male Isolate	14	50%	14	50%	28	100%
Wife	51	84%	10	16%	61	100%
Daughter	14	82%	3	18%	17	100%
Female Relative	10	71%	4	29%	14	100%
Female Isolate	14	41%	20	59%	34	100%
Family Care	20	87%	3	13%	23	100%
Total	187	75%	62	25%	249	100%

As can be seen, even within marriages, there may be someone outside the actual living arrangement who may act as the "king maker," i.e., someone who is the most powerful influence in the patient's community life. It appears reasonable to suppose that, to the degree the patient finds his major support and source of influence outside his family or living group, to that degree will he be affectively marginal to his living group.

Thus, as we can see in Table VIII, above, the significant others in 25% of the cases did not live in the same household; i.e., were not the role partners of the returning patient. In some situations these "external-others" seem to have assumed a guardianship position in relation to the patient; in other situations these "external-others" were parents who continued to be central figures in the patient's life even after his marriage. Isolates, too, even when distant from a face-to-face relationship with significant others in their families, continued to be influenced by them

in 45% of the cases. Thus, overall, the patient's family role position may not, in some cases, provide the only indication of the patient's significant other. In these cases, the divided influence-source may create likely ground for the possible development of confusion and conflict between the patient and his significant other.

When we compare the patient's reasons for his return with his significant other's reason for his return we find, as shown in Table V, that they agreed in 42% of the cases where we had data from both parties.

We will now look at the patient from the significant other's point of view in order to examine some of the reasons for such a lack of consensus between them. We have seen that in one-half of the cases a rehospitalization incident is not an unusual thing to either the patient or his significant other - they have been through this three or more times before the return under investigation. However, when the patient was released from the mental hospital this last time, in 60% of the cases, the significant other indicated that he felt the patient had been ready to leave the hospital. The significant other then had some "hope" for the patient; although one-third of these respondents went on to qualify their hopeful statement by telling us that things had been "fine" for a few days, but soon problems began to crop up once again. From their point of view, the "honeymoon" period had ended.

The patient, on the other hand, stated that he had felt ready to leave the hospital in 79% of the cases. Thus, patients were appreciably more likely to feel they had been ready to leave the mental hospital than were their significant others (Chi-Square = 16.285; $p < .001$). As we can see, the significant other's assessment of the patient was less optimistic than the patient's assessment of himself from the very beginning of the leave period.

This differential assessment of the patient continued throughout his leave period. Such a difference between the patient and his significant other becomes crucial in the areas of expectations of behavior, as Freeman and Simmons have pointed out.(7) In order to study the effect of expectations, we first attempted to learn whether or not the patient and his significant other felt too much had been expected of the patient while he was in the community. Patients felt too much had been expected of them in 27% of the cases while relatives felt people had expected too much of the patient in only 17% of the cases. The patient, therefore, reflected the pressure of too great expectations to a significantly higher degree than did the significant other (Chi-Square = 6.550; $p < .02$).

Employment and Financial Support

We felt this particular question regarding "expectations" was too broad and vague to be an accurate assessment of differential expectations, so we looked at specific areas of the patient's performances and the significant other's assessment of them in order to learn more about how the patient's behavior was viewed by those around him.

One of the primary areas of importance for all adults in our society is their work role. We know this is also an area of special concern to the posthospital mental patient and his family,(8) and we, therefore,

asked both the patient and his significant other a series of three questions regarding the patient's work role. Our first question was whether or not the patient and his significant other felt that the patient had been able to work. As can be seen in the following table, patients and their significant others differed regarding the patient's ability to work while he was in the community. Significant others felt that patients were not able to be employed, while the patients, in general, felt that they were able to be employed. This finding was statistically significant at the .001 level of probability (Chi-Square = 68.34).

TABLE IX: ABILITY TO WORK - STATEMENTS MADE BY PATIENT AND BY PATIENT'S SIGNIFICANT OTHER

Able to Work?	Patient		Significant Other	
	Number	Percent	Number	Percent
Yes	141	64%	50	24%
No	80	36%	158	76%
Total	221	100%	208	100%

The next question, of course, must be raised as to why the patients, who, in fact, stated they felt they had been able to work, did not actually seek or find employment. So we asked both patients and their significant others a question regarding the patients' efforts to obtain work during the time they were in the community. We found that patients whose significant others felt that they had been unable to work did not, in fact, seek employment, but seemed, rather, to accept the significant others' evaluations of their work ability and to lose their confidence about entering the job market. (Table X).

TABLE X: PATIENT'S JOB FINDING EFFORTS AS REPORTED BY THE PATIENT AND BY THE SIGNIFICANT OTHER

Tried to Find Work?	Patient		Significant Other	
	Number	Percent	Number	Percent
Yes	61	25%	46	23%
No	184	75%	155	77%
Total	245	100%	201	100%

As noted previously, only a very few of these returning patients had been able to find any kind of work, no matter how marginal. It would appear from social science knowledge, in general, that work is the basic source of the feelings of self-esteem and identity in most adults. The feeling of being a useful and worthwhile adult stems primarily from the occupational role in our society and for patients to be without any sort of meaningful employment is to give rise to a feeling of general uselessness in the world. To have this feeling buttressed by the attitudes of the significant others toward the patients, i.e., for them to feel that the patients were, in fact, incapable, would seem to produce a malignant climate for both the patients and their significant others.

It is, of course, very difficult to say what the "real" reality might have been in a situation of this kind. One can only assume that patients coming back into the mental hospital would attempt to present their best selves to the interviewer and would resist making a statement that would indicate their inability to work. Therefore, perhaps one could expect to find that patients would say they were able to work when, in fact, they had not felt able to work or even considered it during their stay in the community. On the other hand, relatives might feel that patients were, in general, so incapacitated and socially inadequate that they could not enter the competitive employment market.

At any rate, it would appear that the relatives' evaluations of patients' work skill were a good deal closer to their actual employment history than were the patients' stated evaluations of their own ability to work. A finding of this type raises many unanswered questions, but it does tell us something of the expectation network existing between the patients and their significant others.

We asked both the significant others and the patients about the source of the patients' financial support. Here, too, we noted a modest degree of discrepancy between the patients' views and the significant others' views, Table IX. The major point of discrepancy between them was that significant others were somewhat more likely to say that they were the patients' sources of support, while the patients were more likely to say that they were either self supporting, or were supported as members of their own marital family groups. They both agreed essentially, however, on the patients who were receiving public welfare.

TABLE XI: PATIENT'S SOURCE OF SUPPORT AS REPORTED BY THE PATIENT AND BY THE SIGNIFICANT OTHER

Source of Support	Patient Report		Significant Other Report	
	Number	Percent	Number	Percent
Self or Spouse	113	47%	80	41%
Welfare	83	35%	69	35%
Other	44	18%	48	24%
Total	240	100%	197	100%

When we asked the patient and the significant other about the adequacy of his financial status while he was in the community, the patient was more likely to say that his financial support was adequate than was his significant other. It would seem likely that in this area the patient would be particularly sensitive about his ability to maintain his dignity while in the community and would, therefore, be more likely to say that he had an adequate financial base, whereas the relative would be more likely to feel that his return to the mental hospital was, perhaps, because there had not been enough financial support available within his own family group or in the community to maintain the patient while he was out of the mental hospital, and thus indicate to us that the patient's return was not related to any breakdown in the significant other's role.

In our society, an adult is expected to be "busy," to be purposefully at work either on a job or in home management. A single female or a male adult without employment gets labeled as a "social deviant", and a family's status in the community is lowered by the presence of a non-working adult in the household. Unless such non-working adults are clearly incapacitated, it is the normal expectation of society that they should be meaningfully employed at some instrumental function.

Often ex-patients carry "invisible wounds" - they are not visibly incapacitated, so their unemployability attracts negative labels of "laziness," "mooching upon others," "malingering," etc. Perhaps, in this respect, those persons with some visible handicap, no matter how severe, are better off in the community's eyes. For example, the aged are not as likely to be rehospitalized as are younger patients, (Chi-Square = 3.974; $p<.05$), which may be, in part, due to the fact that in our society the aged person may fulfill a dependent role within a family without undue censure or loss of family status. Indeed, that rare family which provides care for an aged person may actually gain status, thus, in some way turning the dependent aged person within their home into a status asset.

Another example of the consequence of social excusability from normal adult role performance is illustrated by the epileptic patient's fate in the community. While in truth such patients are barred from many kinds of work, they do not generally suffer from the same type of "unemployability stigma" as does the non-physically ill, discharged, mental patient, as they are less likely to be rehospitalized so long as someone will provide adequate medical and financial care for them in the community, even though their behavior may be quite as bizarre or "psychotic" as some "mentally ill" patients.

Use of Time

One of the family's major complaints against ex-patients who are otherwise able-bodied persons is that they "won't work" or that they "just lay around the house all day."*

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* Freeman and Simmons found that relatives complained about this in 18% of their cases (see The Mental Patient Comes Home, p. 47), while our retrospective study found this to be the major social problem given in 10% of the comparable cases.

The level of social participation in community life of ex-state patients is extremely low, as Freeman and Simmons found. In their study of "failures"; i.e., those patients who were rehospitalized within one year, they found less than 10% participated in any kind of activity in a voluntary organization.*

We attempted to investigate how patients spent their leisure time while in the community and in what sort of social activities they participated. We asked both the patient and his significant other about the patient's use of leisure time, and we found a significant difference of opinion between the two (Chi-Square = 19.237; $p < .001$). That is, patients were more likely to outline participation in some type of social life, while their significant others were likely to complain that the patient "didn't do much of anything." Both listed joint family activities as forming whatever primary social life in which the patient participated. Over and over again, both relatives and patients mentioned the extensive use of TV for home entertainment, which seemed to be used by most patients to "pass the time away."

Such findings suggested to us the need of an ethological study of the life styles of ex-mental patients, in comparison with "normals" of the same general social strata in the community. ** We know very little about how unemployed or "unused" adults spend their waking hours in an otherwise busy community.***

We do have some sense of the way such "indolence" is viewed in our society, but we can only speculate about the way the idle or unemployed

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* On the other hand, a recent study of female former patients by Dinitz,(9) at Ohio State University, found that some female patients remain in the community even though their work or domestic performance is irregular and they live in virtual social isolation. However, many females who were rehospitalized were either employed or responsible for the home and led active social lives. We did not find that our female returnees were active socially, although many did tell us they carry on full household management, although we could not assess how adequate such homemaker role performances were. We did note, however, that many of our returning females had aroused the ire of neighbors or family by "bothering" other people, by visiting too often where they were not wanted; they seemed to "wear out their welcomes." Perhaps ex-patients cannot pick up the normal interaction clues that indicate a social encounter should be terminated. Perhaps, in some cases, if they had stayed home or kept out of social interaction while they were "agitated" they would not have been returned at that time. Perhaps patients who stay "hid" and "quiet" have the best chance of avoiding rehospitalization - at least for a time.

** See Dorothy Miller's paper on "Ethology: A Comparative Study of Social Workers and Clients," unpublished paper, School of Social Welfare, University of California, Berkeley, December 1963.

*** Perhaps our only source of information about this type of "non-working" life comes from the beatniks' literature, such as Jack Kerouac's On The Road, or the bitter essay, Subways Are For Sleeping.

ex-patient might come to evaluate his own self-worth in such a situation. It seems unlikely that being "on the shelf" would give the ex-patient any new hope in himself, or any feeling of pride or prestige in the eyes of either his family or the community in general.

Any questions about the patient's community participation must suggest the possibility of the presence of stigma.* We asked both the patient and his significant other if being a mental patient had made it hard for them in the community.** There was a statistically significant relationship between the two groups' replies (Chi-Square = 7.351; $p < .01$). That is, patients were less likely to feel that their mental patient status created a hardship for themselves than were their significant others, who were more likely to complain that the ex-patient status did constitute such a hardship. In 57% of the cases, the significant other felt that the patient's status as a former mental patient also constituted a hardship for the family. Further, of those significant others who stated they felt no hardship, over two-thirds were either family caretakers or significant others who lived outside a face-to-face relationship with the patient. It seems likely that our findings indicate that in those cases where the patient lived in a primary or nuclear family, he did constitute, in the family's eyes, a "hardship" upon them.

Such findings seem to clarify, perhaps, some of the factors which fed the malignant social situation and led the patient or his significant other or both to seek outside help or relief. Failing to obtain such relief led, finally, to a return to the mental hospital for some respite from the "hardships" facing both the patient and his significant other in the community.

Outside Help

We questioned both the patient and his significant other about the type and degree of help they obtained outside of the family. We found three-fourths of the patients had continued to take some type of psychiatric medication and two-thirds of them had been under the care of a doctor while they were out on leave. About 10% had continued to obtain their only medical supervision and psychiatric medication from the mental hospital facility; many of the others obtained initial medication prescriptions from the psychiatrists at the mental hospital, and then transferred their follow-up care to their private family physician. In 20% of the cases,

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* See D. Miller and W. Dawson's "Effects of Stigma on the Re-Employment of Ex-Mental Patients: An Empirical Approach." Mental Hygiene, April 1965, pp. 281-287.

** This question, asked of significant others, elicited a somewhat different dimension of reply than we had anticipated. Patients reacted to this question by telling us about their stigma feelings--about communication blocking, etc., while their significant others also included a "caretaking" aspect in their replies - i.e., they indicated to what degree the patient's "care" had been a burden upon them, as well as noting the stigma effects upon themselves which accrued by having an ex-mental patient in their home.

patients told us that obtaining psychiatric medication had constituted something of a financial problem, while 5% gave this as their reason for either discontinuing or only occasionally using the drugs. We feel, however, that this finding represents only a minimal estimate, since both the patients and their families were reluctant to acknowledge financial difficulty as the reason for the discontinuance of medication.

There were facilities available at the hospital for providing medication to persons who could not afford it, but some patients seemed reluctant to request this medication for fear the request might lead to their rehospitalization.

But the patients, for whatever reason, did discontinue their prescribed medication in approximately one-fourth of the cases, after their release into the community.(10) Generally, these discontinuers stated that the medication "didn't help" or it "made them sleepy," etc.(11) Some stated that it helped at first, but then seemed to lose its effect so that they then discontinued taking it.(12)

In those cases where patients continued to take medication, they told us it helped them to a significantly greater degree than did their significant others (Chi-Square = 13.745; $p < .001$). That is, the significant others felt that, even though patients took medication, it helped them less frequently than the patients thought. Even when patients felt they were being helped by their psychiatric medication, their significant others did not tend to see it that way.

Another possible source of help in the community for both the patient and his family was the Bureau of Social Work, or other community social or psychiatric agency. We asked the returning patient and his significant other about their contacts with social workers from the Bureau of Social Work. Patients indicated they had seen the social worker in two-thirds of the cases. However, patients were significantly more likely to feel that their contacts with the social worker had been helpful to them than were their significant others (Chi-Square = 7.560; $p < .01$). One must wonder at the implications of such a finding - perhaps the family felt the social worker was somehow allied with the patient rather than with the family, or vice versa, since in one-third of the cases where the significant other indicated the social worker had been helpful to him, the patient indicated the social worker had failed to help him. We seem to catch a glimpse here of a three-person triad, with two participants allied against one, in the various possible combinations of a three-person game.*

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* Time does not permit us here to apply game theory for a three-person group to these data, but a subsequent paper is planned on such an analysis. Tentatively from inspection of the data, it would appear that of the three types of combines, (patient and social worker against significant other; significant other and social worker against patient; significant other and patient against social worker), only the first two were likely to be seen among rehospitalized patients. Perhaps the combination of patient and significant other against social worker allowed the patient to remain outside the hospital, albeit the "paranoid" bond between patient and significant other would be a reflection of a mutually held perceptual distortion of the purpose and function of the social worker.(13) Certainly, game theory suggests provocative hypotheses for testing (in a simulation study) the decision-making process within post-hospital patient's worlds. (14) (15) (16)

Rehospitalizing the Patient

We now have a number of findings highlighting prior social situations which seemed to lead to the decision to rehospitalize the patient. In one-third of the cases, the patient volunteered to return himself; in another one-third of the cases, it was necessary for the police or other authorities to be called in by the family to effect the patient's rehospitalization. In the final one-third of the cases, the family had been able to persuade the patient to return without outside allies. In many of these latter cases, the family had the sanction of the social worker as a "persuader."

The actual return was effected in one of two ways: 44% of the patients were first placed in a county psychiatric ward for a short period of time and then returned via state car to the state hospital from the county hospital. The other 56% came directly to the state hospital from their community residence.* Of those who returned directly to the state hospital without a stop-over on a county hospital psychiatric ward, 56% were accompanied by their significant other, while 30% came back by themselves, and the balance (14%) were returned either by the police or professionals.

We now attempt to assess the reasons why these patients returned as stated by both the patient and his significant other. It was possible to classify four types of reasons for the return: 1) psychiatric problems; 2) physical problems; 3) family or environmental stress problems; and 4) drinking problems. We compared each of these four problem types as given by patients, with those given by significant others.

Psychiatric Problems

The significant others were more likely to see the patient's return as a consequence of the recurrence of psychiatric symptoms than were the patients, (Chi-Square = 7.917; $p < .01$). Yet, it must be noted that significant others defined patient's major cause of return as being that of a psychiatric problem in only 57% of the cases. Further, significant others often tended to see psychiatric symptoms as being related, in some way, to the patient's faulty nervous system; i.e., the patient was "nervous," had "headaches," had "spells," etc. In other cases, they saw him as "upset," or "blue," or "worn out." In very few cases did these relatives show any sophistication about, or acceptance of, interpersonal psychiatric principles. And, of course, the patient saw himself as being psychiatrically ill in only one-third of the cases.

When patients referred to their psychiatric problem, it was almost always in terms of being "nervous" or "blue" - a neurological state accompanied by sleeplessness or extreme fatigue. Certainly, we heard little or no use of psychiatric language from either these returning patients or

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* We expected considerable differences in the patients' responses, depending on whether or not they had first been held in a psychiatric ward at a county hospital, but we could find no significant differences between the types of reasons for return given by patients from these two different doorways into the state hospital. In general, it appeared ex-patients remained in county hospitals only a short time before their return.

their families.*

Physical Problems

Patients gave physical problems as the reason for their return in 14% of the cases, and significant others did so in 12% of the cases. Significant others agreed with patients about physical reasons in 31% of the cases (Table VI). Physical reasons were generally given by family caretakers or relatives of aged patients. The reasons, while given in physical terms, i.e., "back pains," "upset stomach," etc., could be recoded by professionals as indications of psychosomatic problems.(17) In any case, it would seem that patients and relatives would expect the mental hospital to offer some form of medical care, rather than only psychiatric therapy.(18)

Such use of the state hospital provides us with some provocative questions about the way these definitions formed and what implications they raise for planning treatment.(19)

Family and Environmental Stress

As we saw above, patients and significant others agreed in only 34% of the individual cases that the reason for the patient's return was due to some form of family or environmental stress (Tables I and VI).

When we compared grouped data, we noted that patients were significantly more likely to see such stress as leading to their return than were their relatives, (Chi-Square = 3.889; $p < .05$). Relatives, in these cases, were likely to define the patients' return in terms of a recurrence of a psychiatric illness. They did not see family conflict or environmental stress as crucial factors in the patients return since, by definition, their own selves would be involved in some way with such a view of the home situation.(20)

In general throughout this study we found significant others disavowing, in one way or another, their involvement in these patients' worlds. So, despite the fact that there is much evidence that these patients probably are liabilities for any "normal" family groups, relatives were not generally able to attribute patients' rehospitalizations to family conflict or environmental stress.(21)

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* This seems to be in marked contrast to chronically returning medical patients who are readmitted several times to a general medical hospital. These medical patients often seem to possess technical words which describe a rather elaborate and precise diagnostic state. Perhaps a comparison study of returnees to both medical and psychiatric hospitals would reveal the vastly different images held of the two institutions by their clientele. Perhaps even the mentally ill do not really think of themselves as "ill" or as having a diagnosis. We have often wondered why mental patients are not told either their diagnosis or the purpose of their "treatment," except in vaguest and most diffuse terms. (See D. Miller's unpublished paper, "County Lunacy Commission.") Could this lack of use of psychiatric terminology represent an unwillingness to accept the state institution as a hospital? These are only provocative questions, and cannot be answered in this research.

Drinking Problem

Only 3% of these returning patients stated that drinking was the reason and 6% of the significant others (omitting unknowns) gave drinking as the reason for patients' rehospitalizations. Patients who offered drinking as the reason found that their significant others agreed in 43% of the cases. As most studies of alcoholism have found[22], patients who drank heavily were somewhat less likely to define themselves as having a drinking problem than were significant others, although this finding, while in the expected direction, was not statistically significant, (Chi-Square = 2.723; $p < .10$).*

Those patients and significant others who gave drinking problems as the reason for return to the mental hospital were generally careful to delineate between their "drinking problem" and psychiatric problems in general. As one patient told us, "I might be a drunk, but I'm not crazy." Further, in almost all cases, a definition of the return as a result of a "drinking problem" often masked a severe state of marital conflict, albeit those marriages were not without some residue of strength in the relationship between patient and spouse. Often the incident of rehospitalization could be seen as a desperate move on the part of a spouse to somehow "save" the badly battered marriage. Spouses often rather plaintively told us that if only the patient would control his drinking everything would be "all right."

In general, spouses had only moved to return these patients after some rather serious acting-out incident in the community, as after a particularly violent aggressive attack upon themselves which brought in either the police or the social worker who urged the return.

In still other cases, the patient chose to define his problem as a drinking problem in order to mask his seriously depressed or suicidal state. In general, as others have found, those patients and families who define their problem as one of alcoholism or excessive drinking tend to resist psychiatric or interpersonal labels and, rather, see their problem as one of establishing control over alcohol consumption. One wonders at the implications of this for, perhaps, A.A. referral or the use of group therapy or antabuse therapy instead of continuing mental hospitalization.

Implications for Treatment

Our research project could not provide answers regarding any implications for treatment which would be based on the patient's definition of the readmitting problem, although this seems to be a fruitful avenue for further study. What would happen if we took the patients' and their families'

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* Perhaps this lack of statistical significance is due to the small number of cases, since only seven of the returning patients and fourteen significant others felt rehospitalization was a direct result of the patient's heavy drinking. State mental hospitals, in general, find that their treatment of alcoholism has had only limited "success," since return rates among alcoholics are greater than those for any other diagnostic group treated there.[23]

definitions of the problem and, in a logical and pragmatic way, gave them the therapy suggested by their problem definition? Such an approach is not new to psychiatry, but no careful studies have been done to evaluate its outcome.

According to one of the practitioners of family therapy with schizophrenics, Nathan Ackerman, the family approach requires psychotherapy of the family group focused upon the existing relationships between the patient and his family.(24) He vividly described the type of family interaction he found in the family life of schizophrenics:

> "A quality of affective deadness pervades the family of the schizophrenic.... The family atmosphere contains a disguised prejudice against new life.... The only shift possible is toward the magic world of fantasy.... There is a pervasive trend of make-believe -- make-believe there is a genuine family bond -- make believe there is deep loyalty and caring - but the family attachments are shadowy and ghostlike. The parents say the right thing, but without feeling.... There is an integrative defect in such families. The adaption of personality to family roles is static and hollow. It critically reduces the capacity to adapt to new experience and to learn." (25)

If we view the ex-mental patient's world through the eyes of both the returning patient and his significant other, we can often document evidences of such affective "deadness." A new world cannot arise in such a stifling climate as Dr. Ackerman described, since such a setting would only lead to world destruction.

We note some support for at least some of Dr. Ackerman's observations in the responses made by significant others to the question, "What changes do you expect further hospitalization to make in the patient?" One-half of the respondents didn't expect any real change or couldn't speculate about a change in the patient in relation to his return to their homes. Further, 30% stated that they only wanted the patient to become his "old self," and seemed to mean by this that he would, in some way, move backwards to establish an earlier relationship stage with them; i.e., to become a "nice obedient child again." The balance (20%) wanted the patient to change in some positive or instrumental way; i.e., to learn how to work, to learn how to take care of himself, etc.

In general, it seemed that most significant others maintained as great an emotional distance as possible from the returning patient, perhaps for their own emotional protection or from a sense of being "worn out" by the destructive interpersonal relationship between themselves and the patient. At any rate, it was difficult to find many positive signs of either hope or acceptance between these patients and their significant others.

The Social Worker's View

We will now examine the social worker's view of these patients' worlds, and seek to investigate what type of casework intervention would seem to be possible in order to help such patients construct a world again after their next release from the mental hospital.

The Bureau of Social Work psychiatric social workers see the ex-patient as still "a patient," albeit a "patient living in the community" - an "outpatient." The social worker offers a range of professional services to leave patients - in many ways these services are similar to those offered in mental health out-patient clinics.

These social workers have been trained to offer casework treatment on an individual or group basis; to understand human behavior in a psychodynamic frame of reference, and to marshal community resources for the patient's use.(26) The wide use of auxiliary social and psychiatric community services requires each social worker to be familiar with both the types and entrance requirements of various community agencies. Such collaboration and cooperation requires the social worker to participate in many planning and coordinating committees, and to represent the social needs of ex-mental patients in the continuous competition for insufficient community resources. Frequently the BSW social worker serves the same persons as do her colleagues in public welfare, public health, vocational rehabilitation, family service agencies, etc.

Leave patients also see other health professionals in the community, mainly psychiatrists or other physicians. It is not unusual for a leave patient to be receiving the services of a general practitioner, a Department of Mental Hygiene convalescent leave psychiatrist, a BSW social worker, a welfare worker, one or more counselors from vocational workshops or employment agencies, and perhaps public health nursing services as well. Such an array of professional "helpers" may create symbolic cleavages, not only in the patient's life, but with the inter-workings of the involved professionals as well.

Our data do not permit us to trace exhaustively the types and numbers of social or medical services received by these returning patients during the time they were out of the hospital, but we do know that in some cases they were multiple and overlapping. They ranged from many contacts with many professionals to no contacts with professionals at all, as shown by these two following examples.

> Patient "A" received family counseling from her priest and from a family service agency worker, and tranquilizing medication from both her family physician and from a Department of Mental Hygiene aftercare psychiatrist. She also received casework services from the BSW social worker and from the Welfare Department's social worker, and underwent a series of psychological tests and interviews from a vocational counselor! All or most of these professionals utilized some form of relationship therapy; all elicited some type of social history, and all sought to influence or change the patient or her environment in some telling way.
>
> Patient "B" generally tried to refuse to seek help or to discuss his problems with anyone. He reluctantly accepted all professional contacts with his "guard up." He resisted the strongest solicitations of the professionals, even when these offers were accompanied by pressure from his significant other. Even when he did receive counseling, medical, or casework services, he failed to

carry out the recommendations made by these professionals.*

In 47% of the cases, the family members seem either to remain distant or to resist becoming involved in the patient's dealings with mental health professionals; i.e., they were not in contact with the BSW social worker, or did not think the social worker had been helpful to the patient or themselves. On the other hand, 16% of the families seemed to have formed alliances with professionals in an attempt to understand, tolerate, or control the patient's seemingly irrational behavior, in that the BSW worker saw only the significant other and did not see the patient. In only 14% of the cases served was there evidence of a clearly defined treatment relationship existing between the ex-patient, his significant other, and professionals, in that the BSW worker saw both the patient and the patient's significant other on more than one occasion. However, two-thirds of these returning leave patients had been seen by a physician for some form of psychiatric medication. In addition, more than one-third of these patients were receiving some form of public welfare and were, thus, seen by a welfare worker in relation to their financial and environmental problems. Thirty-eight percent of these returning patients also had some contact with the police - generally around the incident leading to their rehospitalization.

During these patients' community stay, patients and/or the family were seen by the BSW worker in 70% of the cases. The nature of these contacts varied from contacts with relatives only, to regular or intensive contacts with the patient. In 42% of the cases the BSW worker saw the patient at fairly frequent intervals while he was in the community. In 48% of the cases, the social worker participated in planning for the patient's return to the mental hospital. When they did participate in the patient's return, BSW workers defined the reason for return as a recurrence of psychiatric symptoms more frequently than any other reason.

In 31% of the return incidents, social workers indicated that they had felt before that the patient would eventually have to return to the mental hospital and, in fact, had discussed that possibility with either the patient or his significant other.

What reason did the BSW worker give for the patient's rehospitalization, and how did the professional's view differ from the patient's view of his own return? Among those cases where the social worker had contact with either the patient or his family, they gave reasons for the patient's return, as contrasted with the patient's reason for his return as shown in Table III.

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* Such dilemmas between patients and professionals are by no means confined to the mental health field. This same situation may operate in physical medicine as well, even in so serious an area as cancer treatment where it has been found that one-fourth of the patients resist medical advice or treatment.(27)

As can be seen in Table V, patients and their BSW social workers did not agree in two-thirds of the cases as to the reason for the patient's return. As would be expected, the social worker was likely to see the recurrence of psychiatric symptoms as the most prominent reason for the patient's rehospitalization, while the patient was prone to attribute his return to family and environmental stress.

This lack of consensus between the social worker and the patient regarding his return seemed likely to occur in view of the infrequent contacts between them. How could the social worker know the circumstances of all of the patient's life at any particular time, faced as she is with large and highly mobile caseloads?

We asked the social worker to speculate about these patients' future needs in relation to future community tenure - assuming that most of these returning patients would soon be again released from the mental hospital and would be back on leave of absence. Our question was, "What changes would seem to be indicated that might help this patient remain in the community after his next release?" Social workers' responses to this question were compared with their given reasons for the patients' rehospitalization. We contrasted the BSW workers' suggestions for meeting the future needs of these patients by the two major definitions they gave for the patients' rehospitalization, as shown in Table XII.

TABLE XII: SOCIAL WORKER'S REASON FOR PATIENT'S RETURN COMPARED TO CHANGES THAT THE SOCIAL WORKER FELT WERE NEEDED TO HELP PATIENT AFTER HIS NEXT HOSPITAL RELEASE. (FOR ONLY PSYCHIATRIC AND FAMILY PROBLEMS)

What BSW Feels Patient Needs After Next Release	BSW Reasons for Patient's Return			
	Psychiatric		Family and Environmental Stress	
	Number	Percent	Number	Percent
Environmental Change	32	30%	13	33%
Family Care Placement	18	17%	13	33%
BSW - Psychiatric Treatment	28	26%	3	8%
Don't Know - Doubt Anything Will Help	29	27%	10	26%
Total	107	100%	39	100%

It was somewhat surprising to see that social workers, in general, felt that patients who were rehospitalized because of family or environmental stress must find some new or different living arrangements for their next release from the mental hospital. In less than 10% of the cases of family stress did the social worker feel any type of psychiatric or social therapy could intervene to resolve the family conflict.

When the social worker saw the patient as having a psychiatric problem she recommended continued out-patient psychiatric or casework therapy in only 26% of the cases. Once again we see the social worker largely recommending environmental change or a family care placement for the patient's next release. Such recommendations seemed to reflect an awareness of ex-patients' tenuous relationships with their often rejecting or "worn out" families. These recommendations also reflected the patients' marginal financial status and isolated social position in the community. Perhaps these social workers saw the extreme state of the patients' family disintegration and felt that little remedial work could be done in such deteriorated situations. Certainly our data seemed to suggest that many patients and their significant others were "worlds apart" in the view of the social workers.

However, our data seemed to indicate that the social worker and the patient were also "worlds apart" in many regards. Even when the patient defined his problems as being of a psychiatric nature, his social worker agreed with him in less than one-half of the cases. They were also unable to agree in 82% of the cases on the definition of the patient's problem as resulting from family or environmental stress, although each saw this as a problem - but not in the same cases. Yet the psychiatric social worker was especially trained to deal with social problems arising out of family stress and psychiatric symptomatology. But patients and their social workers did not consensually agree in specific instances that the problems lay in these areas.

We attempted to obtain some data regarding the amount and type of services given to these returning patients prior to their rehospitalization. In 24% of the cases, neither the patient nor his significant other had been seen or contacted by the social worker during the patient's leave of absence. Of those patients who were seen, 40% were seen only once or twice, while another 40% were seen more than twice, and the balance (20%) had been either contacted by phone or referred for service elsewhere.

We endeavored to learn how the patients and their significant others felt they had been helped by the social worker's contacts with them. We learned that, as reported previously, patients were more likely to see the social worker as being helpful than were the significant others. We asked patients to tell us in what way they felt the social worker had been helpful, and we coded the responses, as shown in Table XIII.

TABLE XIII: PATIENTS' COMMENTS AS TO THEIR SOCIAL WORKERS HELPFULNESS (N = 162)

	Number	Percent
Vague Comment - "Talked nice", etc.	124	76%
Affective Gain	4	3%
Problem Resolved	11	7%
Didn't Help	23	7%
Total	162	100%

It appeared that while 86% of the patients felt their social workers had been helpful in some way, they were largely inarticulate about just what had transpired in the exchange which had been helpful to them. Often one caught the feeling of wistfulness from the patient who indicated that it was just "nice" to be an object of interest and concern to someone holding a superior status. Many of these patients found communication with anyone difficult, so it was not surprising that they were unable to take an analytical stance regarding their relationship with their social worker.

Some examples of the "vague" comments patients gave were as follows: "She was trying to help--I don't know." "I liked the visit; I can't explain it." "In a way, she gave me a chance to talk." "She gave me a chance to talk about what I wanted to." "She was very nice, talked to me, made me feel good."

Some patients mentioned an affective gain from contacts with the social worker. Some examples of these types of comments were: "I could depend on the social worker. She was on my side and I knew she would understand." "Very encouraging--helped build my morale." "It gave me a feeling of encouragement." "Gave me encouragement to help myself. I needed someone."

Some patients mentioned various types of problems that the social worker had helped to resolve for them. Some examples of these statements were: "Helped with finding work; gave me hope." "She didn't have much to say, but she helped me get my benefit papers fixed up."

Some patients felt the social worker wasn't able to be helpful to them and the following comments illustrate this group of responses: "Social service not necessary. I'm not sick." "Didn't help - I don't know why." "I don't think she helped. She talked so much it was hard to keep up with her." "She did her best, but I felt there was a barrier--probably on my part." "I don't want her services. I don't need her."

It seemed apparent from our data that most patients felt that "talking things over" with an interested person had been helpful to them, although many times they were not able to delineate clearly in just what ways "talking had helped."

We also asked the patient's significant other if they felt the social worker had been helpful to the patient. As noted above, patients were more likely to see the social worker as a source of help for themselves than were their significant others. In 53% of the cases, significant others felt the social worker had been of some help to the patient. However, we did not specifically ask the significant other if the social worker had been helpful to them. Our only measure of the presence of a helping relationship between the social worker and the patient's significant other was the way in which the social worker participated in planning with the significant other around the patient's rehospitalization.

Social workers participated in planning the patient's rehospitalization in 47% of the cases. Such participation frequently involved a consultation with the patient's significant other. In fact, almost all significant other-social worker contacts centered around planning for the

patient's return to the mental hospital. Conversely, when such joint planning did occur, the social worker tended not to see the patient, but to communicate only with the patient's family, generally by telephone. Many returns seemed to erupt as some form of "crisis," at least in the eyes of the patient's significant other or the professionals. In one-third of the cases police were also called in by the significant other actually to take the patient out of the home and to place him back in either the county hospital ward or the state mental hospital. In cases where the social worker was involved in planning the patient's rehospitalization, she tended to agree with the significant other in 40% of the cases that a prior return had been indicated.

Such consensus between social workers and relatives seemed to point out the fact that many family situations had been deteriorating over a period of time and that possibly the family had exhausted their tolerance of the patient. It seemed that in these cases the social worker saw the patient's rehospitalization as a therapeutic necessity, if not for the patient, then for whatever part of the family unit still remained intact.

Thus, in general, social workers moved in a variety of ways in their attempts to work out the patient's and family's many complex and difficult social and personal problems. If anything, most social workers seemed very practical and pragmatic about their approach to these patients' complex worlds. Despite the patient's failure to remain outside the hospital, less than 20% of the social workers indicated a loss of hope about the patient's next try at social living outside the mental hospital. These social workers did not necessarily look upon the patient's rehospitalization as a "failure" in most cases but, rather, tended to view the patient's return to the hospital as a temporary respite from a too difficult community career.

On the other hand, there seems to be considerable evidence from our research that both patients and their significant others view each incident of rehospitalization as another diminishment of hope and as another "social defeat" which have consequences for patients' future social adjustment chances. The fact of failure, of stigma, of lowering self-confidence, of rejection of future chances to build a new world seemed much more prominent in both the patients' and the significant others' responses than they did in the social workers' assessment of the total situation. Social workers find that over 40% of their leave cases are rehospitalized in any twelve month period. The individual incident loses its impact when it seems to be such a "natural course" of leave of absence careers. Thus, social workers were able to make quite a different over-all assessment of the meaning of an individual patient's rehospitalization. After all, for every patient whose case is terminated by a return, the social worker sees two other patients being released; she must move on to new and evermounting pressures of her job. One has fallen, but the job goes on.

SUMMARY

We sought a three dimensional view of the rehospitalized mental patient's disbanded world. We have analyzed our interview data by considering the professional and personal requirements of each of the three major participants in the patient's return to the mental hospital.

We interviewed 249 returning patients and 203 of their significant others. We obtained information from 227 of their BSW psychiatric social workers, as well. From these data we attempted to examine the post-hospital patient's community career, which had been disbanded for a time when he re-entered the state hospital.

These returning patients had been in the community for an average of 6.4 months; three-fourths of them had previously been on leave of absence, while another one-fourth had been on leave five or more times prior to their present return.

The bulk of these returning patients (84%) had been committed as mentally ill, and 60% had been diagnosed as schizophrenic. Forty-five percent had previously received electroshock therapy; three-fourths of these patients had been released on hospital prescribed doses of psychiatric drugs after a relatively short period of time in the hospital.

About one-third had returned to take up their former life with a spouse - often with minor children in their home. During the time these spouses had been in the community, 10% of them had become divorced or separated and several others were undergoing continuing severe marital conflict.

Twenty-one percent of these patients had resided with their parents, and often these parent-child relationships were hostile and rejective; some seemed typical of the symbiotic relationships described by Nathan Ackerman and other observers of schizophrenic families.

Ten percent of these returning patients had resided with relatives; usually these patients were older widows or widowers who had lived with their adult children. They often seemed like unwanted, aging Cinderellas who held down a corner chimney seat in a cold stepdaughter's palace.

Another 9% had been family care patients who were being returned from a foster home placement that, after all, hadn't worked out for them.

The rest (27%) had been living outside of their families, and could be classified in the "isolate" role. Often these patients had lived in skid row hotels or boarding houses and had few close contacts of any kind with other persons.

Only 37% of these patients had been able to find any kind of employment, no matter how meager, during their stay in the community. Of those in the labor market, two-thirds had been unskilled workers and earned less than subsistence amounts.

We next sought for relationships among the three perspectives of the return incident held by the patient, his significant other, and the social worker. We felt these would give us a better understanding of the meaning of the patient's rehospitalization to himself, to his family, and to his community.

We found that patients and their "immediate others" defined their return to the mental hospital in a variety of ways, which we felt could be broadly categorized into four groups of reasons: 1) psychiatric problems; 2) physical problems; 3) family or environmental stress problems; and 4) drinking problems.

We first sought agreement or consensus about the reason for the patient's rehospitalization from the three respondents. Overall, we found only 16% of the three respondents agreed as to the reason for the patient's return to the mental hospital.* In those 29 cases where all three respondents agreed as to the nature of the problem which led to the patient's re-entry into the state hospital, 19, or 66% of such agreement was based on the definition of the patient's return as being the result of a "psychiatric problem." Family or environmental problem was mentioned by 6, or 21% of these respondents who agreed; while 2, or 7% of those who agreed defined a physical problem, and another 2 (7%) agreed on a drinking problem as leading to the patient's rehospitalization.

TABLE XIV: AMOUNT OF CONSENSUS FOUND AMONG THREE PERSPECTIVES REGARDING THE REASON FOR THE PATIENT'S REHOSPITALIZATION (N = 182)†

Concensus	Patient's Reasons: Psych. No.	%	Fam. Stress No.	%	Physical No.	%	Drinking No.	%	Total No.	%
Agree	19	29%	6	7%	2	7%	2	33%	29	16%
No Agreement	47	71%	77	93%	25	93%	4	67%	153	84%
Total	66	100%	83	100%	27	100%	6	100%	182	100%

(† All cases eliminated which did not have responses from all three participants.)

* We found that we were able to obtain all three responses from only 182, or 73% of our total cases interviewed. This shrinkage was due to a number of factors, as explained in the methodology section. Our computation of 16% total consensus is derived from those 182 cases which had all three responses available for analysis, since we eliminated the incomplete sets; i.e., those with only responses from the patient or from the patient and one other.

Yet, overall, the amount of agreement between respondents regarding the reason for the patient's rehospitalization was very small and, as can be seen in Table XIV, the findings point up the existence of vast definitional chasms among the three respondents.

Agreement among the three respondents was greatest percentagewise in those cases where a drinking problem or a psychiatric problem was given as the return reason. These agreements were significantly greater (Chi-Square = 14.932; $p < .001$) than those definitions of the problem given as arising from family-environmental stress or from physical problems.

We then looked at the degree of consensuality held between two respondents--the patient and his significant other--as to the reason for his return. We found that agreement between these two existed in only 42% of the cases. We found, further, when we examined the specific problem areas, that those significant others who did agree with the patient's definition of his return agreed as follows: 42%, psychiatric problem; 43%, drinking problem; 31%, physical problem; and 34%, family and environmental stress problem. Thus, when the patient's significant other did agree with the patient as to the reason for his rehospitalization, he was more likely to see his problem as being a psychiatric one rather than agreeing with him that the problem arose from family or environmental stress.

Further, we found that the patient and his social worker agreed on the reason for the patient's return to the state hospital in only one-third of the cases - while the patient's significant other and the patient's social worker agreed on a common reason for the patient's return in one-half of the cases. That is, social workers and patients were less likely to define the patients' problems consensually than were social workers and patients' significant others. When social workers did agree with patients on a common definition of the reason for patients' return, they had the greatest amount of specific definition agreement in the areas of drinking or psychiatric problems. The least amount of agreement was found between the social worker and the patients on the definition of the patient's return as being due to the patient's physical condition.

Between social workers and patients' significant others, the amount of agreement, while also low, was in the same direction as the agreement between social workers and patients. The major difference found was in the evaluation of physical and family stress as being the reasons for the rehospitalization. Social workers were less likely to see either of these reasons as prevailing than were the significant others. In general, social workers - as would be expected from their professional background - were more likely to interpret most of the patients' complaints within a psychodynamic framework. Thus, they viewed the patient's rehospitalization as a result of a display of psychiatric symptomatology, regardless of the way the returns were defined by either the patient or his family.

Patients, in general, saw their problems as arising out of family conflict or environmental stress--but they did not find agreement from their immediate others. In those cases where the patient defined his problem as being of a psychiatric nature, he found the greatest amount of support from professionals. However, agreement was found in less than one-half of these cases, showing that even when patients took on a psychiatric definition of

their problem, they were not always reinforced in this view by professionals.

Such a spectrum of reasons for patients' returns, with varying amounts of support from significant or professional others, raises many provocative questions about the dimensions of posthospital patients' civilian worlds.

Many social scientists and practitioners have suggested that consensus between a client and a therapist is important in the formulation of a therapeutic relationship. If a common situational definition is a necessary preliminary step to helping a patient, then many questions must be raised as to the interpersonal crises which led these patients to being returned to the mental hospital without effective intervention from professionals.

In summary, our findings show a considerable rift between returning mental patients, their families, and their social workers as to a congruent view of the patient's situation. For example, many families complained that ex-patients would not work even when they, themselves, indicated that the patient was not able to work. Relatives indicated they felt a considerable degree of hardship due to the presence of an ex-mental patient in their home. They often complained that the patient was "too much care," or that they were uncomfortable with the patient in their home. The patients and their relatives turned to psychiatric medication for relief of this interpersonal tension, but often stated that medication did not help smooth the troubled waters. Families also did not feel that the social workers were effective in helping the patient adjust either in their home or the community.

Many patients were returned by significant others who presented themselves as being "worn out with" or totally rejective of the patient. At any rate, most signs of family affection toward the patient were notably lacking in our data from the patients' significant others. In general, data from the social workers, too, seemed to indicate that the situation between the patient and his family was one of a mutually destructive nature. Social workers often suggested that the patient go somewhere else to live following his next release from the mental hospital. Also, the patient often indicated that he too wanted to live elsewhere in the future. All of our respondents seem to present evidence of considerable social disruption in the lives of ex-mental patients and their families.

If, as our findings seem to indicate, returning mental patients' civilian careers are full of discontinuity and disillusionment; if patients must disband former civilian worlds after each release; if patients are in a continuous process of alienation from their significant others, what must be done to begin to help them build a new world after each release from the mental hospital? What services must the community provide for such a group of state ex-mental patients?

Our findings seem to suggest that we must take a more realistic view of each ex-patient's social assets, resources, and perspectives if we are to be able to help him reconstruct a disbanded world. We must use the family's help in more realistic ways, taking into account the old or still-open interactional wounds, and help these families slowly to construct or reconstruct relationships with the patient. It would appear that professionals will need new tools of environmental manipulation, such as multi-

purpose welfare, housing, vocation, and recreational aids if they are to have a more meaningful impact upon the reconstruction of new worlds for posthospital mental patients.

C O N C L U S I O N *

(Overview of Findings in Part I and Part II of "Worlds That Fail")

A. BACKGROUND

In the United States, between 80% and 85% of the mentally ill are cared for in State or Federal Institutions. The balance, according to Public Health Reports, are treated in private psychiatric facilities or in local community hospitals. This indicates the significance and importance of studying the state mental hospital population, since it involves such a large proportion of the mentally ill.

During the past decade, significant and radical changes in the length of hospitalization have occurred. While patients are released earlier, they are also returned to the hospital more frequently than before. No longer is the career of the state mental patient one of lifetime residence in mental institutions - now, the majority begin their mental patient careers with a relatively short stay in the mental hospital and are then released for out-patient follow-up and medication service. They may spend long periods of time in the community between hospitalizations--returning to the mental hospital at times of psychiatric crisis or social stress. For example, in California, 85% of all patients are released within the first six months following their admission; while one-half of these patients are directly discharged, the other half are placed on leave of absence status and are given follow-up care in their own community by psychiatrists and psychiatric social workers. Of these released patients, approximately 40% are rehospitalized within the first year following their release.

One of the released patients told us: "Once a mental patient, always a mental patient." This patient was referring not to the re-entry rate, but, rather, to her feelings of stigma and self-derogation--which follows many released mental patients like a long, haunting shadow, for all of their lives.

The definition of oneself as a mental patient generally occurs at the point of admission to a mental hospital, yet the social and psychological consequences of such a definition continue--perhaps for a lifetime. The empirical study of stigma, as it is defined by Erving Goffman is, of course, an extremely difficult task.

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* This section of the report formed the basis for a paper which was presented at the First International Congress of Social Psychiatry in London, England, August 1964, by William Dawson, M.S.W.

B. OVERVIEW OF PART I:
(Five Year Retrospective Study of Posthospital Patients' Community Careers)

We conducted a survey of 1,045 California posthospital mental patients in order to investigate the social conditions which attend mental patients' careers. We first noted the incidence of rehospitalization and found that 71% of all released patients had been returned to the mental hospital at least once, and 24% had been rehospitalized on the average of 4.4 times each. We found, confirming the findings of other studies, that approximately 85% of these released mental patients came from the lowest socioeconomic class; that 65% had less than a high school education; that only 26% found any type of employment after their release, while 27% were totally dependent upon public welfare as their source of support.

Ex-patients often found their former way of life shattered beyond repair with each release from a state hospital. They underwent a constant drainage and depletion of their social resources with each state hospital stay.

We then examined the family role positions filled by these posthospital mental patients. The construct family role position was derived from three age groupings (young, middle-aged, old), from sex, and from the patient's basic living arrangement; i.e., "spouse," "child," "relative," or "isolate."

We found ex-patients were less likely to be married than other persons, in that, while in California 85% of all adults are married, only 48% of the posthospital patients were spouses. The majority of the ex-patients held tangential or marginal family role positions--they were not heads of households nor did they play decisive roles in family function, maintenance, or support. In general, they could be described as dependent and marginal persons, often an unwelcome guest in another's home.

We found that one-third of these released patients changed from one family role position to another following their mental hospitalization and that, of those who changed, 90% changed from a close-other role to a more distant-other role; i.e., from spouse to child, or from relative to isolate. Such role change seemed one indication of the fragile hold ex-patients have upon their former family identities and how marginal they had become in playing any major role in family life.

Two major social roles form the primary identity structure for an adult in western society - the family role and the work role. Ex-patients in our study were, in general, on the fringe of both of these adult roles. For example, before their admission to a mental hospital 13% of the patients had been employed in white collar positions; following their release only 4% found any type of white collar position. Another 29% had been employed as blue collar workers prior to their admission to the mental hospital, while only 12% found employment of any kind after their release. Therefore, following their release from the mental hospital, only 16% of these patients were able to find any kind of full time employment, while another 16% found only part time or sheltered employment. Thus, posthospital patients underwent downward movement in both adult roles following their hospitalization.

Faced with such marginal or inadequate adult roles, what then was the attitude of the patient and his significant other toward his problems? We found that since only 36% of these ex-patients were able to support themselves, they were financially as well as emotionally dependent upon others. Many of the isolates lived in skid-row hotels, dependent upon public welfare. Those who filled adult-children roles found themselves living with aged parents who themselves were frequently dependent upon old age assistance or Social Security benefits. Those who lived with other relatives often found themselves occupying Cinderella roles in someone else's chimney-corner.

Among those who were married, 69% were wives. They had an average of 2.4 minor children in their homes, and 40% of these wives were unable to adequately carry out their major household responsibilities. Among the husbands, less than one-half were employed; 80% had a serious drinking problem and often assumed the dependent position within their marriage. Of those ex-patients who were married, 55% were experiencing extreme marital conflict, and 30% of the children of the ex-patients were also experiencing difficulty with school or juvenile authorities.

In short, these ex-mental patients lived in or on the edge of multi-problem families. Often their return to the mental hospital came about as just one more incident of social and family disruption so common among those persons in our society who live from one crisis to another--always on the precipice of disaster.

These patients' psychiatric conditions seemed only one part of the total social crisis facing them as they moved from the mental hospital ward into the world outside. Among these patients, 60% had been diagnosed as schizophrenic, 11% as organic or having a central brain syndrome, 15% had a depressive psychosis, 4% were mentally retarded, [illegible]% alcoholic, and the balance, 6%, had a variety of personality disorders or neuroses.

At the time of their release from the hospital, however, 18% were judged to be "chronic" - still suffering from some form of psychiatric condition. Nearly two-thirds were released and continuing some form of drug therapy, although a large percentage of them discontinued their drugs--often against medical advice. During their period in the community, 29% of these patients continued to have occasional hallucinations and delusions; another 21% suffered serious periods of depression; while 25% were arrested for drunkenness or other mildly antisocial behavior.

This brief review of some of the overall social characteristics of our sample of 1,045 leave patients provided us with many provocative questions; e.g.:

1) What were the differences between those ex-patients who were re-hospitalized and those who were able to remain in the community?

2) What were the reasons for the patients' return to the mental hospital?

Theoretical Framework of the Ex-Patients' Worlds

To answer the first question, we studied a series of psychological

and social factors regarding patients who did not return and compared them with those who returned. We used the theoretical framework provided by Erving Goffman, who suggested that in order for a person to build a world, four devices would be necessary. His analogy was drawn from "The Big Con Game," where men plot to construct an "unreal" world for an unsuspecting "mark" in order to fleece him. The devices needed for construction of a false world are needed for construction of any sort of "world." We attempted to show how these same elements are needed to build a posthospital patient's world. Goffman posited the following devices necessary to world-construction--there must be:

1) Elaborate and complete material, equipment, and multiple "shills" available to develop the "set-up"--to structure the world.

2) An intimate agent to be with the "mark" all the time in order to provide constant assurance of his new identity. This person must reinforce the main source of the other's new definition of the world by continuously supporting the "frame" which has been established by the equipment and the shills.

3) Those situations and persons who will deal with the "mark" in a spontaneous manner, as though there were no prearranged script when, in fact, there is. This apparent spontaneity creates a guarantee of "real" reality.

4) A controlling person to get in the first word defining each new situation. Such "first words" develop control over the situation and set up the frame of reference for the interaction of all those within that situation.

We then developed a series of propositional statements derived from Goffman's suggested world building devices:

(1) a released mental patient who has an adequate source of material support

PLUS

(2) a professional group who assure him that he is now "well"

PLUS

(3) an interested significant other who supports the view of the professionals as to his social adequacy

PLUS

(4) a series of natural opportunities for social relationships with others

EQUAL:

ability to remain in the community.

[I.e., (1) + (2) + (3) + (4) = "success."] Conversely, those who do not have these four factors present in their world will return to the mental hospital, or in some other way fail to establish a satisfactory posthospital life.

Our findings from this study regarding adequate equipment (proposition 1), were that those patients with an adequate source of support were significantly more likely to remain out of the hospital than were those with an inadequate source of support, who were more likely to be rehospitalized (Chi-Square = 26.015; 1 df; $p < .001$). Another indication of the importance

of the equipment for world building was the finding regarding the source of support of ex-patients, whether self or spouse supported, supported by welfare, or supported by other relatives. We found that those patients who were able to remain in the community were either self or spouse supported, while those who were supported by welfare or were dependent upon parents or relatives were significantly more likely to be rehospitalized (Chi-Square = 25.834; 3 df; $p < .001$).

In regard to proposition 2, pertaining to the role of "shills" or professionals who set the stage, we found that the type and amount of after-care services offered to the patient and his family were not related to outcome. One exception were those patients who had been placed on psychiatric medication while on leave, who were significantly more likely to be rehospitalized than were those patients who were not placed on medication (Chi-Square = 23.910; $p < .001$). This finding is not starling when we recognize that placing the patient on medication may itself have been an endeavor by professionals to avoid the patient's imminent rehospitalization.

However, we found that of the 20% of the cases who received no after-care services, (because they resisted contacts with the psychiatric staff, because they left without a forwarding address, or because they were thought to be in good remission and, hence, not to need close or continuous follow-up), were able to remain out of the mental hospital significantly better than those patients who were followed by the after-care staff (Chi-Square = 15.327; 1 df; $p < .001$). We felt that these "non-served" had been better able to take the "well" role and had also been supported in it both materially and emotionally by their significant others and the professionals; i.e., their "shills."

We buttressed this interpretation of Goffman's "world building" hypothesis by looking at that portion, 28%, of those cases in which both the patient and his significant other had a positive attitude toward the follow-up service. These patients were significantly more likely to be able to remain out of a state hospital than were those patients who did not develop a consensual attitude with their significant others toward after-care (Chi-Square = 20.601; 1 df; $p < .001$).

Thus, it might be said that when either the professional group felt the patient was "well enough" not to need psychiatric services, or when the patient and his significant other agreed that the patient required services, the patient would likely be more capable of "building a world."

In discussing proposition 3, which deals with the role of the patient's interested significant other, we found that patients who filled a "close-other" family role position were significantly more likely to manage to remain in the community than were those patients who filled "distant-other" family role positions (Chi-Square = 22.432; 5 df; $p < .005$).

A "close-other" family role position would be that of a spouse. A patient who returned to reside with his parents or other relatives would occupy a "distant-other" or a "tangential-other" position. A patient who lived outside of a family or kinship group would fill a "marginal-other"; i.e., a "distant-other" family role position.

"World-building" seemed to require support from a "close-other" role partner--if the ex-patient was not sufficiently integrated to fully rebuild his own world. To the degree that he was sidelined within a family group--to the degree that he was a person of low status in regard to his kinship group--to that degree he would fail in his attempt to construct or reconstruct a world outside the mental hospital walls. This finding was further buttressed when we discovered a significant relationship between a positive attitude toward the patient held by his significant other and that patient's ability to avoid rehospitalization (Chi-Square = 5.866; 1 df; $p < .02$).

However, while some researchers, such as Freeman and Simmons, found that the expectations held by the patient's family was a significant determinant of outcome, our data did not reveal any significant relationship between the significant others' expectations of patients' instrumental role performance and the patients' ability to remain in the community, although the trend was in that direction (Chi-Square = 1.795; 1 df - not statistically significant; $p < .20$; $> .10$).

We feel that these findings tended to support Goffman's view that the significant others are an important plank in rebuilding the posthospital patient's world.

In order to discuss both this proposition and the fourth proposition, we now turn to our second study which investigated the reasons for the patient's return to a mental hospital as given by himself, by his significant other, and by his psychiatric social worker.

Goffman's hypothesis makes an important, but subtle, psychological point regarding the necessity of the appearance of "spontaneity" in the business of world-building. That is, one judges an event to be "really real" if it seems "spontaneous." For the ex-mental patient, such spontaneous welcome and acceptance of himself as a "normal" or "beloved" and "respected" person seems essential in his attempt to construct a new world.

C. OVERVIEW OF PART II: DISBANDED WORLDS (Returning Mental Patients from Three Perspectives)

We found, in our study of returning patients - i.e., patients who had failed to build a world, or who had disbanded their worlds - a mass of evidence of breakdown of communication between the patient and his family, as well as many signs of overt rejection. Certainly, neither the patient, his family, or his professional social worker were portraying a "spontaneous" welcome or respect for his capabilities. For example, one-third of the patients did not know they were being rehospitalized at the time of their re-entry into the mental hospital, while frequently both the professional social worker and the patient's significant other had collaborated in planning his return. Such breach of "trust" seemed common practice in the interaction between patients and their significant others.

In our interviews with patients, we asked them why they were being rehospitalized, and we found that 42% of the patients felt they had to return to the hospital because of family or environmental stress. The family, however, did not agree with the patient but felt, rather, that his return was related to his psychiatric problem or to his antisocial

behavior (Chi-Square = 28.9; $p < .001$).

Overall, we found that in only 16% of the cases did all three respondents agree as to the reason for the patient's rehospitalization. Thus, it would seem that returning patients do not see a "spontaneously" real world which assigns them the role of a "well person." Rather, they are defined differently by both their significant others and their professional others, so that no consensually-held definition of their new world developed or was maintained for any length of time.

In Goffman's proposition 4, he posited that the initial definition of a situation along which the subsequent interaction would proceed was an important factor in building a world. We found in our interviews with the patients' significant and professional others, that patients saw themselves as being "well" at the time of their release more frequently than did their significant others, who tended to view them as still being "the same," or as having been released from the mental hospital "too soon" (Chi-Square = 3.918; $p < .05$). We saw this finding as an indication that patients who were confronted with "ill" definitions of themselves held by others would not be capable of building a new world outside the hospital.

In general, we felt our findings supported Goffman's theoretical framework regarding the devices needed to construct a world. Findings from our two studies were also descriptive of other important social and psychological factors which helped to determine which ex-patients would be able to remain in the community as compared with those who were rehospitalized.

D. THE PROBLEM AND THE CHALLENGE

The treatment problem confronting those of us who work with hundreds of thousands of state patients who fill one-half of all the hospital beds in America is enormous. We must face up to the importance of understanding more fully the social and psychological factors which help determine the conditions under which posthospital mental patients would be able to build a new world outside the hospital walls.

What must the community offer such patients and their families in order to assist them in this building of a new world?

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APPENDIX I

FREQUENCY DISTRIBUTION TABLES

A. SOCIOLOGICAL DATA

Table 1: Sex

	Number	Percent
Male	106	43%
Female	143	57%
Total	249	100%

Table 2: Age

Under 21	9	4%
21-29	43	17%
30-39	95	38%
40-49	29	12%
50-64	52	21%
65-74	14	6%
75 and over	7	3%
Total	249	100%

Table 3: Ethnic Grouping

Caucasian	190	76%
Negro	39	16%
Spanish American	9	4%
Oriental	5	2%
Other	6	2%
Total	249	100%

Table 4: Present Marital Status

	Number	Percent
Single	66	27%
Married	81	33%
Separated	36	14%
Divorced	36	14%
Widowed	30	12%
Apart but not estranged	-	-
Total	249	100%

Table 5: Number of Marriages

Unknown	66	27%
One	130	52%
Two	39	16%
Three	10	4%
Four or more	4	2%
Total	249	101%

Table 6: Religion

Unknown	8	3%
Protestant	93	38%
Protestant, church named	50	21%
"Pseudo" Protestant	8	3%
Catholic	83	34%
Jewish	1	-
Buddhist	2	1%
Other, specify	1	-
None	3	1%
Total	249	101%

Table 7: Occupational Identity

	Number	Percent
Unknown	1	-
Executive, proprietor large concerns, major professional	2	1%
Manager, proprietor medium concerns, lesser professional	3	1%
Administrative personnel large concerns, owner small business	10	4%
Owner little business, clerical, sales	18	7%
Skilled worker	18	7%
Semi-skilled worker	18	7%
Unskilled worker	87	35%
Housewife or never employed	68	27%
Incapacitated - not employable	24	10%
Total	249	99%

Table 8: Education

Unknown	4	2%
Grade school	62	25%
Some high school	107	44%
High school graduate	40	16%
Some college	22	9%
College graduate	5	2%
Special professional training	2	1%
Special trade training	1	-
None	6	2%
Total	249	101%

Table 9: Patient's Significant-Other

	Number	Percent
Unknown	1	-
None	6	2%
Spouse	79	32%
Parent (s)	58	23%
Child	16	6%
Sibling	20	8%
Other relatives	14	6%
Friend	16	6%
Commercial (landlady, etc.)	11	4%
Professional (M.D., social worker)	1	-
Other, specify	27	11%
Total	249	98%

Table 10:

Family Role Position when Last Released from Hospital

Husband	26	10%
Son	35	14%
Male relative	11	4%
Male isolate	19	8%
Wife	54	22%
Daughter	17	7%
Female relative	14	6%
Female isolate	15	6%
Female family care	15	6%
Male family care	8	3%
Wife w/minor child	7	3%
Shared non-family (male)	9	4%
Shared non-family (female)	19	9%
Total	249	102%

Table 11:

Family Role Position upon Return to Hospital

	Number	Percent
Husband	22	9%
Son	29	12%
Male relative	9	4%
Male isolate	29	12%
Wife	53	21%
Daughter	17	7%
Female relative	11	4%
Female isolate	19	8%
Female family care	14	6%
Male family care	9	4%
Wife w/minor child	7	3%
Shared non-family (male)	8	3%
Shared non-family (female)	22	9%
Total	249	102%

Table 12: Type of Patient's Family Role Change

Unknown	2	1%
Spouse to child	3	1%
Spouse to relative	2	1%
Spouse to isolate	3	1%
Child to isolate	7	3%
Relative to isolate/child/spouse	11	4%
Other to spouse	4	2%
Isolate to relative/child	7	3%
Family care to other	2	1%
Other, specify	1	-
Not applicable, no role change	207	83%
Total	249	100%

Table 13: Reason for Family Role Change

	Number	Percent
Unknown	11	4%
Death	1	-
Divorce, separation	8	3%
Interpersonal conflict	11	4%
Change in jobs, family care	3	1%
Living arrangement changed	5	2%
Other, specify	2	1%
Not applicable, no change	208	84%
Total	249	99%

B. HOSPITAL & RETURN FROM LEAVE STATUS DATA

Table 14: Length of Mental Illness

	Number	Percent
Less than one year	33	13%
One year	33	13%
Two years	19	8%
Three years	22	9%
Four years	16	6%
Five years	22	9%
6 - 10 years	52	21%
11 - 15 years	22	9%
16 - 20 years	16	6%
20 - 29 years	14	6%
Total	249	100%

Table 15: Number of Re-entries into Hospital

One	66	27%
Two	58	23%
Three	35	14%
Four	28	11%
Five to nine	55	22%
Ten or more	7	3%
Total	249	100%

Table 16: Average Time Spent in State Hospital

	Number	Percent
Unknown	1	-
Less than 1 month	11	4%
1 - 3 months	75	30%
4 - 6 months	53	21%
More than 6 months to 1 year	63	25%
Two years	24	10%
3 - 5 years	13	5%
6 - 9 years	4	2%
10 or more years	5	2%
Total	249	99%

Table 17:
Average Length of Time Out of State Hospital

Unknown	2	1%
Less than 1 month	20	8%
1 - 3 months	36	14%
4 - 6 months	54	22%
More than 6 months to 1 year	78	31%
Two years	37	15%
3 - 5 years	19	8%
6 - 9 years	3	1%
10 or more years	-	-
Total	249	100%

Table 18: Type of Last Commitment

Mentally ill	208	84%
Alcoholic	2	1%
Voluntary	39	16%
Total	249	101%

Table 19: Time Spent in State Hospital-Last Admission

	Number	Percent
Less than 1 month	11	4%
1 - 3 months	93	37%
4 - 6 months	54	22%
More than 6 months to 1 year	53	21%
Two years	18	7%
3 - 5 years	8	3%
6 - 9 years	7	3%
10 or more years	5	2%
Total	249	99%

Table 20: Time out of State Hospital since Last Release

Less than 1 month	32	13%
1 - 3 months	72	29%
4 - 6 months	45	18%
More than 6 months to 1 year	81	33%
Two years	14	6%
3 - 5 years	4	2%
6 - 9 years	-	-
10 or more years	1	-
Total	249	101%

Table 21: Patient's Mode of Transportation to Hospital

Significant other	69	28%
Professional	4	2%
Authorities (police, etc.)	14	6%
State car from county hospital	110	44%
Friend	3	1%
Self	42	17%
Other, specify	7	3%
Total	249	101%

Table 22:

Time Interval between Return to Hospital and Interview

	Number	Percent
Unknown	3	1%
Less than one hour	72	28%
One hour	16	6%
Two hours	15	6%
Three hours	14	6%
Four to eight hours	13	5%
Nine to fifteen hours	27	11%
Sixteen to twenty-three hours	37	15%
Twenty-four to thirty-one hours	10	4%
Thirty-two to forty-seven hours	17	7%
Forty-eight hours or more	25	10%
Total	249	99%

Table 23: Day Returned

Monday	34	14%
Tuesday	52	21%
Wednesday	33	13%
Thursday	39	16%
Friday	58	23%
Saturday	10	4%
Sunday	21	8%
Holiday	2	1%
Total	249	100%

Table 24: Hour Returned

A.M. (work hours)	34	14%
P.M. (work hours)	140	56%
Between working hours	46	18%
A.M. (non-work day)	4	2%
P.M. (non-work day)	25	10%
Total	249	100%

Table 25: Law Agent Involvement in Return of Patient

	Number	Percent
Unknown	1	-
Law agent initiated return	12	5%
Law agent called by others	81	33%
Law agent counseled others	2	1%
No contact, no involvement	153	62%
Total	249	101%

C. PSYCHIATRIC TREATMENT DATA

Table 26: Latest State Hospital Diagnosis

	Number	Percent
Schizophrenia	89	36%
Schizophrenia, paranoid	60	24%
Chronic brain syndrome, etc.	30	12%
Personality disorder	17	7%
Depression	33	13%
Mentally retarded	5	2%
Alcoholic	15	6%
Total	249	101%

Table 27:
Most Radical Type of Prior Hospital Treatment

Lobotomy	2	1%
Electroshock	110	44%
Drugs	118	47%
Psychotherapy	2	1%
Milieu, custodial	17	7%
Other, specify	-	-
Total	249	100%

Table 28: Type of Last Leave of Absence

	Number	Percent
Home leave	222	89%
Family care, private sanitarium, etc.	26	10%
Work placement	-	-
Not applicable	1	-
Total	249	99%

Table 29:
Other (Community) Psychiatric Care Received

None	200	80%
Out-of-state psychiatric hospital	18	7%
Veterans Administration hospital	9	4%
Private sanitarium	8	3%
County hospital psychiatric ward	1	-
Out-patient	13	5%
Total	249	99%

D. THE PATIENT'S PERSPECTIVE OF HIS WORLD

Table 30:
Patient's Opinion of Readiness for Last Leave

	Number	Percent
Unknown	14	6%
Yes	197	79%
No	18	8%
Don't know	13	5%
No response	7	3%
Total	249	101%

Table 31: Patient Thought Return to Hospital Likely

Unknown	8	3%
Yes	87	35%
No	150	60%
No response	4	2%
Total	249	100%

Table 32:

Patient's Fore-Knowledge of Plan for Return

	Number	Percent
Unknown	2	1%
Yes	166	67%
No	78	32%
No response	3	1%
Total	249	101%

Table 33: Patient's Reasons for Return

Unknown	4	1%
Don't know, just for medication, "check up"	22	9%
Victimized by others, tricked into return	47	19%
Suicide attempt	3	1%
Physically ill	35	14%
Family conflict	37	15%
Nervous, upset, psychiatric symptoms	52	21%
Incoherent, irrelevant responses, etc.	25	10%
Language difficulty	1	-
Drinking problem	7	3%
No place else to go	16	6%
Total	249	99%

Table 34: Patient's Estimate of Ability to Work

Unknown	8	3%
Yes	141	57%
No	80	33%
Yes and no	14	6%
Not applicable	3	1%
No response	3	1%
Total	249	101%

Table 35: Patient Held Job While on Leave

	Number	Percent
Unknown	4	2%
Yes	90	37%
No	94	38%
Not in labor market	58	24%
No response	3	1%
Total	249	102%

Table 36: Patient Tried to Find a Job

Unknown	4	2%
Yes, got one	24	10%
No	38	16%
Not applicable	143	58%
Yes, couldn't find one	37	15%
No response	3	1%
Total	249	102%

Table 37:
Patient's Statement Regarding Source of Support

Unknown	9	4%
Self-support	68	28%
Public welfare, benefits, etc.	83	33%
Spouse	45	18%
Relatives, parents	36	14%
Other, specify	3	1%
No response	5	2%
Total	249	100%

Table 38:
Adequacy of Living Expenses According to Patient

Unknown	8	3%
Yes	142	57%
No	89	36%
No response	10	4%
Total	249	100%

Table 39: Patient Saw a Doctor While on Leave

	Number	Percent
Unknown	11	4%
Yes	149	60%
No	83	33%
No response	6	2%
Total	249	99%

Table 40: Patient Took Psychiatric Medication

Unknown	9	4%
Yes, regularly, it helped	100	40%
No	62	25%
Yes, occasionally, it helped	14	6%
Yes, at first but stopped	17	7%
Yes, regularly, didn't help	27	11%
Yes, occasionally, didn't help	10	4%
Other	3	1%
No response	7	3%
Total	249	101%

Table 41: Patient Saw the Bureau Social Worker

Unknown	15	6%
Yes	168	67%
No	62	25%
No response	4	2%
Total	249	100%

Table 42:
Patient's Statement Regarding Social Worker's Helpfulness

Unknown	13	5%
Yes	120	48%
No	32	13%
Yes and no	19	8%
No response, not seen	65	26%
Total	249	100%

Table 43:

Patient's Comments Regarding Help by Social Worker

	Number	Percent
Unknown	18	7%
Vague, general response	124	50%
Affective gain after talk with BSW	4	2%
General problem resolution	1	-
Specific problem resolution	10	4%
Didn't want help - resistive	5	2%
Didn't help - felt pressure (negative)	18	8%
Not applicable, no response, not seen	69	28%
Total	249	100%

Table 44: Patient's Statement Regarding Stigma

Unknown	16	6%
Yes	100	40%
No	128	51%
No response	5	2%
Total	249	99%

Table 45: Patient Felt People Expected Too Much

Unknown	21	8%
Yes	67	27%
No	153	61%
No response	8	4%
Total	249	100%

Table 46: How Patient Passed Time

	Number	Percent
Unknown	6	2%
Home work	91	37%
Home leisure, alone	15	6%
Outside social life w/others	24	10%
Looked for jobs	15	6%
Employed	39	16%
Nothing much	47	19%
Social life w/family only	2	1%
No response, inappropriate	10	4%
Total	249	101%

Table 47: Patient's Future Plans

Unknown	8	3%
Nothing, don't know, etc.	43	17%
Return to family	52	21%
Seek employment, return to job	65	26%
Leave past situation	17	7%
Begin new life, vague	39	16%
Begin new life, realistic	11	4%
No response, irrational, etc.	14	6%
Total	249	100%

Table 48:

Patient Wishes to Return to Same Living Arrangement

Unknown	14	6%
Yes	148	59%
No	76	31%
Don't know	7	3%
No response	4	2%
Total	249	101%

E. SIGNIFICANT OTHER'S PERSPECTIVE OF THE PATIENT

Table 49:

Patient Ready to Leave the Hospital According to Significant Other

	Number	Percent
Unknown, no contact	50	20%
Yes	119	48%
No	50	20%
Yes and no	18	9%
Don't know	12	5%
Total	249	102%

Table 50:

Significant Other's Reason for Patient's Return to Hospital

Unknown, no significant other	42	17%
Afraid, uneasy w/patient	10	4%
Suicidal attempt	3	1%
Physically ill	25	10%
Drinking problem	12	5%
Family conflict	18	7%
Psychiatric symptoms	89	36%
Other, specify	36	14%
Don't know, etc.	7	3%
No response	7	3%
Total	249	100%

Table 51:

Significant Other Thought Earlier that Patient Might Have to Return

Unknown	45	18%
Yes	90	36%
No	101	41%
No response	13	5%
Total	249	100%

Table 52:

Significant Other's Reason for Prior Return Planning

	Number	Percent
Unknown	50	20%
No prior return planned	103	41%
Belligerent, hard to manage	24	10%
Wouldn't stop drinking	6	2%
Depressed or regressed	29	12%
Some thought of this but no reason given	20	8%
Illness	3	1%
No response	14	7%
Total	249	100%

Table 53:

Patient's Willingness to Return According to Significant Other

Unknown	44	18%
Yes, volunteered	72	29%
No, was persuaded	33	13%
No, family brought him in	25	10%
No, authorities returned him	71	29%
No response	4	2%
Total	249	101%

Table 54:

Significant Other's Estimate of Patient's Work Ability

Unknown	43	17%
Yes	50	20%
No	118	47%
Yes and no	28	11%
No response, no contact	10	4%
Total	249	99%

Table 55:

Significant Other's Statement of Patient's Employment

	Number	Percent
Unknown	44	17%
Yes	61	24%
No	138	55%
No response, no contact	6	2%
Total	249	98%

Table 56:

Significant Other's Evaluation of Patient's Efforts to Seek Work

Unknown	48	19%
Yes, got one	46	18%
Not applicable, not ready, etc.	83	33%
No	37	15%
Yes, couldn't get one	8	3%
Sporadic, yes and no, tried	12	5%
No response	15	6%
Total	249	99%

Table 57:

How Patient's Living Expenses Were Met According to Significant Other

Unknown	52	21%
Self-support	41	16%
Public welfare, benefits, etc.	69	28%
Spouse	39	16%
Relatives, parents	32	13%
Other, specify	3	1%
No response	13	5%
Total	249	100%

Table 58:

Adequacy of Patient's Living Expenses
According to Significant Other

	Number	Percent
Unknown, no contact	56	22%
Yes	96	39%
No	54	22%
No response	43	17%
Total	249	100%

Table 59:

Patient Saw a Doctor
According to Significant Other

Unknown	58	23%
Yes	128	51%
No	55	22%
No response	8	3%
Total	249	99%

Table 60:

Patient Took Medication for His Illness
According to Significant Other

Unknown	66	27%
Yes, regularly, it helped	37	15%
No	58	23%
Yes, occasionally, it helped	15	6%
Yes, stopped, didn't help	21	8%
Yes, regularly, didn't help	27	11%
No response, no medication	25	10%
Total	249	100%

Table 61:

Helpfulness of Bureau Social Worker
(Significant Other's Statement)

	Number	Percent
Unknown	70	28%
Yes	46	18%
No	30	12%
Yes and no	11	4%
No response	92	37%
Total	249	99%

Table 62:

Patient's Leisure Time Activity
According to Significant Other

Unknown	48	19%
Home work	61	24%
Home leisure, alone	13	5%
Outside social life w/others	11	4%
Looked for jobs	9	4%
Employed	15	6%
Nothing much, TV, reading	77	31%
Social life w/family only, family care	5	2%
Ran around too much, bars	4	2%
No response	6	2%
Total	249	99%

Table 63:

Hardship Due to Patient at Home
According to Significant Other

Unknown	56	22%
Yes	106	43%
No	70	28%
Yes and no	9	4%
No response	8	3%
Total	249	100%

Table 64: Significant Other's Over-Expectation of Patient

	Number	Percent
No response, unknown	57	23%
Don't know	12	5%
Yes	33	13%
No	145	58%
Yes and no	2	1%
Total	249	100%

Table 65:
Significant Other's Future Living Arrangements for Patient

No response	54	22%
Don't know	49	20%
At home with parents	30	12%
At home with spouse/children	49	20%
At home with other relatives	7	3%
Someplace else	19	8%
By themselves, alone	16	6%
Family care or nursing home	14	6%
Should remain in the hospital	5	2%
Other, specify	6	2%
Total	249	101%

Table 66:
Anticipated Changes by Hospital in Patient's Behavior According to Significant Other

Unknown	57	23%
Learn to accept supervision, etc.	4	2%
Become "old selves," relax, etc.	37	15%
Stop drinking	9	4%
Help himself	24	10%
Learn how to work	3	1%
No change required, check up	14	6%
Irrelevant response	15	6%
No response, don't know, etc.	86	35%
Total	249	102%

F. SOCIAL WORKER'S PERSPECTIVE (BUREAU OF SOCIAL WORK)

Table 67:

Social Worker's Reason for Patient's Return

	Number	Percent
Unknown	22	9%
Drinking problem	18	7%
Psychiatric symptoms	100	40%
Financial, environmental	24	10%
Suicide attempt	3	1%
Medical advice, physical	8	3%
Patient volunteered	4	2%
No where else to go	12	5%
Picked up by police	3	1%
No response, don't know	55	22%
Total	249	100%

Table 42: BSW Participation in Patient's Return

Unknown	3	1%
Yes	118	47%
No	107	43%
No response	21	8%
Total	249	99%

Table 69:

Bureau Worker's Opinion That Earlier Return was Indicated

Unknown	7	3%
Yes	74	30%
No	104	42%
No response, don't know	64	26%
Total	249	101%

Table 70: BSW Contacts with Patient

	Number	Percent
Unknown	61	24%
Seen only once	41	16%
Seen twice	30	12%
Seen frequently	68	27%
Seen routinely, as in family care	34	14%
Referred elsewhere, seen there	2	1%
Relatives only contacted	2	1%
Talked on phone only	4	2%
No response	7	3%
Total	249	100%

Table 71: BSW Contacts with Significant Other

Unknown, no contact	113	45%
Phone contact with significant other or family	34	14%
Family seen, significant other, family care	40	16%
Routine only, as in family care	16	6%
No response, no significant other	46	18%
Total	249	99%

Table 72:

Social Worker's Estimate of Patient's Future Community Needs

Unknown, no contact	51	20%
Financial assistance, employment	18	7%
Family care, nursing home	43	17%
Help with alcoholism	5	2%
Medical care, psychiatric	11	4%
BSW contacts	29	12%
Environmental change	24	10%
Doubtful anything help	13	5%
Other, specify	17	7%
Marital counseling	2	1%
No response	36	14%
Total	249	99%

G. INTERVIEWER'S EVALUATION OF SITUATION

Table 73:

Interviewer's Clinical Impressions of Patient

	Number	Percent
Unknown	1	-
Retarded development	10	4%
Emotionally deprived	73	29%
Unstable development	39	16%
Compromised development	14	6%
Distorted development	52	21%
Circumstantial disintegration	46	19%
Organically-induced disintegration	14	6%
Total	249	101%

Table 74:

Interviewer's Evaluation of Patient's Interaction

Unknown	1	-
Open, accepting, cooperative	126	50%
Resigned, depressed, passively, cooperative	44	18%
Anxious, nervous, disturbed or easily upset	27	11%
Defensive, critical, superficially, cooperative	34	14%
Hostile, verbally resistive, uncooperative	4	2%
Unresponsive, memory loss, out-of-contact	8	3%
Language barrier	5	2%
Total	249	100%

Table 75:

Evaluation of Significant-Other Person's Attitude

	Number	Percent
Unknown	49	20%
Open, accepting, cooperative	85	34%
Resigned, depressed, passive	2	1%
Nervous, disturbed, easily upset	-	-
Defensive, critical, superfical	4	2%
Mailed form, no evaluation	109	44%
Total	249	101%

Table 76: Type of Significant-Other Response

Unknown	5	2
Interviewed by William Dawson	93	37%
Responded to mailed form	110	44%
No response to mail or phone	27	11%
Unable to locate or contact	6	2%
No significant other	8	3%
Total	249	99%

FORM I

INTERVIEW WITH PATIENT

_____
(Study #)

Name:_____ Study#:_____

Date & Hour Returned:_____

Date & Hour Interviewed:_____

23 ☐ 1. How does it happen that you are back in the hospital? What do you think was behind your return?

24 ☐ 2. Have you felt, before this time, that you might have to come back to the hospital? _____Yes _____No _____NR.
If yes: Why did you think you might have to come back?

25 ☐ 3. Did you know you were going to be taken back to the hospital? _____Yes _____No _____NR.
Who brought you back.

26 ☐ 4. With whom did you live when you were out of the hospital? Did you move around? Why?

27 ☐ _____# of patient's changes in Family Role Position.

28 ☐ 29 ☐

Initial Role	Spouse	Child/other Relative	Parent with Minor child.	Shared Non-family	Isolate
Spouse					
Child/other Relative					
Parent w/ Minor child					
Shared Non-Family					
Isolate					

Name_____

30 [ ] 5. Do you consider yourself able to work? ___Yes___No___NR.
If No: Why not?

31 [ ] 6. If yes to 5: Did you have any kind of a job? ___Y.___N.___NR.
If yes: What did you do? Was it like work you used to do?

32 [ ] If no: Did you try to find a job? Where? When? Why not?

33 [ ] 7.a) Did you see a doctor while on leave? ___Y.___N.___NR.
If yes: What for?

34 [ ] b) Did you take any medication while you were on leave?___Y.___N.___NR.
If yes: Did you take your medication? How often? Why not?
Did it help?

35 [ ] 8. How did you meet your living expenses? Was this adequate?

36 [ ]

37 [ ] 9. Did you see the BSW worker while you were on leave?
___Y.___N.___NR.
If yes: How often?_____Did they help?_____
In what ways?

38 [ ] If no: Why not?

Name_____

39 ☐ 10. What did you do to pass the time away? (Home; housework, maintenance, T.V., reading, entertaining, hobby. Away from home: Movies, church, automobile, bars, visiting.)

40 ☐ 11. Did it seem to you that being a mental patient made any difference in getting along on the outside?

In what ways?

41 ☐ 12. Did it seem to you that people expected too much of you___Y.___N.___NR. If yes: In what ways?

42 ☐ 13. What do you look forward to when you leave the hospital?

43 ☐ Do you want to return to the same living arrangement? ___Y.___N.___NR. Why?

44 ☐ 14. When you went on leave from the hospital, did you feel you were ready to leave?

45 ☐ 15. Evaluation of appearance & condition, etc.

46 ☐

Form 1-pp 3 (NIMH 1269-1)
Note: Form 2 covered the same subjects as Form 1 except that the questions were rephrased to be appropriate for significant others.

FORM 3

REASONS FOR RETURN TO THE MENTAL HOSPITAL (MH 1269-1): BSW WORKERS' INFORMATION

To be completed by the Bureau of Social Work worker assigned to this patient's case. (If case was uncovered or not contacted, please indicate.)

Give your professional opinion, based on your present knowledge of the situation.

Patient's Name: _____ Hospital Number: _____

70 ☐ 1. Why did the patient have to return to the hospital? _____

_____

_____

_____

71 ☐ 2. Did you participate in plans to return the patient to the hospital?
Yes ☐ Comment: _____
No ☐

_____

72 ☐ 3. At any time prior to the time of return, did you feel a return was indicated? Yes ☐ If yes, explain: _____
No ☐

_____

73 ☐ 4. How often was the patient and/or his family interviewed? Comment:
74 ☐ _____

75 ☐ 5. What changes would seem to be indicated that might help this patient remain in the community after his next release?

_____

_____

_____

76 ☐ 6. Advise address of interested relative or significant other, if known
Name: _____

Address: _____

_____ Telephone Number: _____